89- 18

No.

Supreme Court, U.S.
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IN THE SUPREME COURT

OF THE UNITED STATES

OCTOBER TERM, 1988

OREGON PHYSICIANS' SERVICE,
an Oregon nonprofit corporation,

Petitioner,

v.

JOHN HAHN, WADE LIGGETT,
JOSEPH AIZAWA, V.G. LIVINGSTON,
HUGH FRASER, and HIDE AIZAWA,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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QUESTIONS PRESENTED

The Ninth Circuit's opinions in this important antitrust litigation raise issues inimical to the provision of health care to consumers in an efficient and competitive manner. Those published opinions conflict with the results reached and the legal standards applied by this Court and courts in other circuits.

In opinions authored by Circuit Judge Fletcher, the Ninth Circuit rulings may dismember and deter a wide range of efficient and competitive cost containment efforts by health care consumers, purchasers, providers, indemnitors, and insurers. The Ninth Circuit had reversed the first summary judgment for the Blue Shield defendant granted on grounds of McCarran-Ferguson Act exemption and lack of interstate commerce. On remand, after the completion of all discovery and numerous proceedings leading to an evaluation on the merits, the District Court granted a second summary judgment where, although claiming damages of millions of dollars, the six individually named plaintiffs failed to produce evidence of conspiracy, market power or abuse thereof, or antitrust standing or injury. In reversing this summary judgment on the merits, the Ninth Circuit attempts to resurrect and extend theories from a Fourth Circuit opinion dating from the beginning of this decade. Since that Fourth Circuit opinion, other courts have rejected similar claims and upheld decisions for Blue Shield defendants in the First, Second, Third, Fifth, Seventh, and Eighth Circuits. Other courts, including this Court and the Fourth, Sixth, Tenth, and Eleventh Circuits, have rejected similar claims and upheld decisions for health care defendants in structurally indistinguishable factual circumstances.

As a result, these six remote individual plaintiffs--who in fact lack standing--are able to condemn competitive activities of this Blue Shield defendant under a flawed banner of "*per se*" violations of the federal antitrust laws, without any proof of conspiracy, restraint, or injury.

The Ninth Circuit reached these anomalous results by its contrary resolution of these fundamental legal questions:

1. Can the sole defendant, a nonprofit corporation created under Oregon statutes and supervised by the Oregon Insurance Commissioner as a health care service contractor, be charged with "conspiracy" with its own members?

    a. If so, is not such a "conspiracy" "vertical" - rather than "horizontal," where the sole defendant and the plaintiffs do not compete?

    b. If so, can such a "conspiracy" be inferred from the mere fact that some physician members might compete with plaintiffs, where such physicians are not on the corporate defendant's board or do not make policy or payment decisions?

2. Can "price-fixing" be inferred from the mere fact that the sole defendant takes a confidential survey of its members' various fees for service, and then determines on its own how to reimburse for services rendered by nonmembers to its subscribers, leaving nonmembers such as plaintiffs free to charge fees at whatever level each wants and to collect from their own patients whatever amount is not reimbursed by defendant?

a. If so, can plaintiffs prevail against the purchaser/indemnitor defendant where their own patients have already paid them for services rendered?

b. If so, can such "vertical" "price-fixing" be condemned as a "*per se*" violation?

3. Can a "group boycott" be inferred from the mere fact that the sole defendant had not yet extended membership to plaintiffs' category of health care provider, where the Oregon state statutes make a distinction between plaintiffs' category and medical and osteopathic doctors, specifically prohibit the plaintiff providers from performing certain procedures which medical and osteopathic doctors may perform, and require plaintiffs to be supervised by medical or osteopathic doctors in certain circumstances?

a. If so, can plaintiffs prevail without showing detriment to the market or market power?

b. If so, can plaintiffs prevail even though plaintiffs have not demonstrated injury to competition?

PARTIES TO THE PROCEEDINGS

Petitioner Oregon Physicians' Service ("OPS") was the only appellee and defendant below on this summary judgment.

Respondents were named as the appellants and plaintiffs below. They were: John Hahn, Wade Liggett, Joseph Aizawa, Hide Aizawa, V. G. Livingston, and D. Hugh Fraser.

As noted by the courts below, on March 1, 1983, petitioner OPS, a "Blue Shield" corporation, merged with Northwest Hospital Service, doing business as Blue Cross of Oregon, and the named plaintiffs subsequently became participating physicians in the resulting organization, known as Blue Cross and Blue Shield of Oregon. App. A at 6 (868 F.2d at 1025 n.2); App. B at 26 (860 F.2d at 1504 n.2). Blue Cross and Blue Shield of Oregon is involved in a joint venture--Oregon Preferred Care Network, an Oregon nonprofit corporation--with Good Samaritan Hospital and Medical Center, a nonprofit corporation, Tuality Management Systems, a stock corporation, Portland Adventist Medical Center, a nonprofit corporation, Northwest Physicians' Association, a stock corporation, Pacific Physicians' Association, a stock corporation, and Portland Alliance for Health, Inc., a stock corporation.

Other parties, previously involved but dismissed from these proceedings before the latest summary judgment for petitioner and the following appeal, are listed in a prior petition for a writ of certiorari in this matter involving questions of interstate commerce and McCarran-Ferguson Act coverage. See petition No. 82-1773.

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Petitioner Oregon Physicians' Service ("OPS") respectfully prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Ninth Circuit.

OPINIONS BELOW

The latest summary judgment opinion of the District Court appears as App. C in the Appendix. The opinions of the Court of Appeals are reported at 868 F.2d 1022 and 860 F.2d 1501 and appear as App. A and B in the Appendix. (Previous opinions are published at 508 F. Supp. 970 and 689 F.2d 840 and appear in the appendix to petition No. 82-1773 as App. A and B.)

JURISDICTION

The judgment of the Court of Appeals was entered, as amended, on February 27, 1989 (App. D). A timely petition for rehearing was denied on March 31, 1989 (App. E). Jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The Sherman Act, 15 U.S.C. § 1 *et seq.*
The Clayton Act, 15 U.S.C. § 12 *et seq.*
The Oregon Podiatrists Statutes, ORS 682.010.
The Oregon Insurance Code Insurance Policies Statutes, ORS 743.006-009.
The Oregon Insurance Code Health Care Service Contractors Statutes, ORS 750.005-075.

(All contained in the appendix to petition No. 82-1773, App. G through M.)

STATEMENT OF THE CASE

The Initial District Court Opinion.

An organization known as Fair Action Committee for Education ("FACE") filed this action in September, 1978, alleging that the petitioner-appellee-defendant-health care service contractor conspired to boycott podiatrists in favor of other physicians in violation of the Clayton Act, 15 U.S.C. § 12 *et seq*, and the Sherman Act, 15 U.S.C. § 1 *et seq*. Later, a number of individual podiatrists withdrew from the litigation, and the few remaining podiatrists substituted an amended complaint, losing FACE as a plaintiff and prosecuting the action in their names only. (The action has not been prosecuted as a class action, and now there are six named individual plaintiffs.) After initial discovery OPS moved for summary judgment, and the United States District Court for the District of Oregon, Judge Solomon presiding, granted the motion on February 27, 1981.

With respect to the McCarran-Ferguson Act, the District Court noted that OPS was a regulated health care contractor under ORS 743.006, 743.009, 746.160(3), and 750.005 *et seq*. 508 F. Supp. at 972 n.1, 975. The District Court found that there were services involving the foot which Oregon podiatrists may not perform, and held that there was a rational basis for the policy limitations on the coverage of podiatric care, supported by the licensing provisions under the Oregon Podiatrists Statute, ORS 682.010(3). 508 F. Supp. at 974. The District Court distinguished and rejected the Fourth Circuit's analysis in *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981) (*"Virginia Academy"*), noting that the holding in that case must be considered in connection with Virginia's "Freedom of

Choice" statute (Va. Code § 38.1-824), which contrary to the Oregon statutes here, prohibited health insurers from differentiating between services rendered by different providers. 508 F. Supp. at 974-975. The District Court then found that no boycott was involved here, noting that OPS did not control the health insurance market. The District Court also found that plaintiffs had failed to present any evidence of concerted action. 508 F.Supp. at 975-976.

With respect to jurisdiction, the District Court found that under the tests set forth, *inter alia*, in *McLain v. Real Estate Board of New Orleans*, 444 U.S. 232 (1980) (*"McLain"*), plaintiffs had failed to show a "not insubstantial effect" on interstate commerce. 508 F. Supp. at 977.

The First Ninth Circuit Decision.

On the record before it, a Ninth Circuit panel held that because the challenged activities did not appear to be part of the "business of insurance," the McCarran-Ferguson Act exemption was inapplicable, and it reversed the District Court's findings that plaintiffs had failed to meet the interstate commerce requirement.* 689 F.2d at 841-844.

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* OPS petitioned for a writ of certiorari on the grounds that that panel decision was in direct conflict with *McLain*, *Crane v. Intermountain Health Care, Inc.*, 637 F.2d 715 (10th Cir. 1980) (en banc) (*"Crane"*), and *Cordova & Simonpietri Ins. v. Chase Manhattan Bank*, 649 F.2d 36 (1st Cir. 1981) (*"Cordova"*) with respect to the interstate commerce test, and that the panel had misapplied the McCarran-Ferguson Act. That petition was denied at that time. 462 U.S. 1133 (1983). The Eighth Circuit has since rejected the Ninth Circuit interstate commerce holding here, noting it conflicts with the decisions in *McLain* and *Crane*. *Hayden v. Bracy*, 744 F.2d 1338, 1343 n.2 (1984). A district court has also noted the direct conflict between other

The District Court Opinion on Remand.

On remand, after full discovery by both sides and proceedings designed to focus on the issues to be decided by the court, the District Court, District (now Circuit) Judge Leavy presiding, ultimately granted OPS' motion for summary judgment on the grounds that plaintiffs still had failed to produce evidence of a conspiracy, following the Third Circuit decision in *Pa. Dental Ass'n v. Medical Services Ass'n of Pa.*, 745 F.2d 248, 258 (1984), *cert. denied*, 471 U.S. 1016 (1985) (*"Pennsylvania Blue Shield"*), and that plaintiffs had failed to produce evidence of injury to competition, following this Court's decision in *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 488 (1977) (*"Brunswick"*).

The Second Ninth Circuit Opinion.

On plaintiffs' second appeal, the second Ninth Circuit panel here reversed on the grounds that an "inference" of conspiracy could be drawn from the fact

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*cont.

circuits' decisions and the Ninth Circuit decision here. *Litman v. A. Barton Hepburn Hosp.*, 679 F. Supp. 196, 200 (N.D.N.Y. 1988) (citing *Cordova; Furlong v. Long Island College Hospital*, 710 F.2d 922 (2d Cir. 1983); *Seglin v. Esau*, 769 F.2d 1274 (7th Cir. 1985); *Hayden*; and *Crane* as rejecting the *Hahn* and other Ninth Circuit decisions). *See Sarin v. Samaritan Health Center*, 813 F.2d 755, 758 & n.1 (6th Cir. 1987) (following *Cordova, Furlong, Seglin, Hayden,* and *Crane* in rejecting Ninth Circuit interstate commerce test). The Eighth Circuit has also come to a different conclusion regarding the application of the McCarran-Ferguson Act to another Blue Shield plan. *Health Care Equalization Com. v. Iowa Medical Soc.*, 851 F.2d 1020, 1027-1029 (1988). This Court has not yet resolved this split in authority, and it may be time for this Court to review the interstate commerce and McCarran-Ferguson Act standards on the expanded record now developed here after full discovery.

that some physicians might compete with plaintiffs and some other noncompeting physicians were on the board of OPS; the fact that OPS had some policies that provided for reimbursement of its subscribers for services rendered by nonmembers at an indemnity schedule of less than 100 percent (while having other policies, including some that provided for reimbursement at 100 percent of the fee billed by nonmembers such as plaintiffs) could constitute "*per se*" "price-fixing"; and plaintiffs might be able eventually to come up with evidence that OPS "boycotted" plaintiffs. The panel reached these results by applying burdens of proof and persuasion on defendant OPS, rather than plaintiffs, and following the decision in *Virginia Academy*. 860 F.2d at 1505,1507, 1508-1510 (App. B at 27, 28, 32-33, 34-37, 40).

The Third Ninth Circuit Opinion, Amending the Second.

The panel later amended its opinion. Although it deleted one of the sentences in its original opinion regarding burden of proof and persuasion, it followed the same analysis and achieved the same result. Further, it added a new footnote (868 F.2d at 1029 (App. A at 14-15) n.5), and substituted language for some of the portions. 868 F.2d at 1030 (App. A at 17-18). The Ninth Circuit noted that plaintiffs have withdrawn any Sherman Act § 2 claims. 868 F.2d at 1026 (App. A at 8) n.3.

REASONS FOR GRANTING THE WRIT

Courts in other circuits have rendered decisions diametrically opposed to the Ninth Circuit decisions here regarding the legality and effect of similar health care arrangements. Such a conflict presents the paradigm for granting certiorari under this Court's Rule 17.1(a). Likewise, the difference in results highlights the conflict between the decisions here and this Court's decisions,

presenting a separate reason for granting certiorari under this Court's Rule 17.1(c).

Certiorari is particularly appropriate because the conflicts dramatize legal issues fundamental to the proper enforcement and application of the Sherman Act: the need to honor the balance struck by Congress in the Sherman Act, which allows unilateral conduct by corporations unless it tends towards abuse of monopoly power and prohibits only unreasonable restraints of trade that injure competition. Here, the Ninth Circuit has upset that balance by allowing remote plaintiffs to proceed on "*per se*" theories against "vertical" conduct by a single defendant who has little "market share," conduct that neither unreasonably restrains trade or injures competition.

Faced with standards so amorphous that the same practices can be simultaneously condoned and condemned by different courts, health care planners have no way of rationally conducting activities. This uncertainty can seriously deter the competition the antitrust laws seek to encourage in this important developing sector of the national economy. As this Court emphasized in *Texas Industries, Inc. v. Radcliff Materials, Inc.*, 451 U.S. 630, 637 (1981), with respect to another private federal antitrust question: "any discussion of this problem must consider the problem of 'overdeterrence,' *i.e.*, the possibility that severe antitrust penalties will chill wholly legitimate business arrangements." To allow the Ninth Circuit opinions here to stand would "chill wholly legitimate business arrangements" for health care throughout the Ninth Circuit and this Nation.

I

The Intra-Enterprise and "Walking" Conspiracy Theories Accepted by the Ninth Circuit Here Have Been Rejected by Courts in Other Circuits Applying Principles Set Forth by This Court, so That There Should Be No Finding Here of Conspiracy With OPS--The Defendant Corporation--and Its Own Members.

The Ninth Circuit here allows plaintiffs to proceed on two "intra-enterprise" theories of "conspiracy," in spite of plaintiffs' failure to identify a single "co-conspirator." Plaintiffs argued that the sole defendant, OPS, somehow conspired with its own unidentified members, and that somehow OPS is, itself, a "conspiracy." Either way, plaintiffs cannot prevail under a "conspiracy" theory: in the first instance because they have failed to identify, much less prove, a "conspiracy" with any "co-conspirators"; and in the second, because it is not possible as a matter of law. The nonprofit corporation here, created under Oregon statutes and supervised by the Oregon Insurance Commissioner as a health care service contractor, cannot be charged with "conspiracy" with its own physician board members. Nor can plaintiffs prevail under a theory that defendant, itself, is a "conspiracy" of its members.

The Ninth Circuit panel ignored these fundamental principles, resulting in conflict with this Court's decisions in *Monsanto Co. v. Spray-Rite Service Corp.*, 465 U.S. 752 (1984) (*"Monsanto"*) and *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752 (1984) (*"Copperweld"*), the First Circuit's decision in *Kartell v. Blue Shield of Massachusetts, Inc.*, 749 F.2d 922 (1984), *cert. denied*, 471 U.S. 1029-1030 (1985) (*"Blue Shield of Massachusetts"*), the Fourth Circuit's decision in *Cooper v. Forsyth County Hosp. Authority, Inc.*, 789 F.2d 278, *cert. denied*, 479 U.S. 972 (1986) *("Cooper")*, the Sixth

Circuit's decision in *Potters Medical Center v. City Hosp. Ass'n.*, 800 F.2d 568 (1986) (*"Potters"*), and the Tenth Circuit's decision in *McKenzie v. Mercy Hosp. of Independence, Kansas,* 854 F.2d 365 (1988) (*"McKenzie"*).

Following *Monsanto*, this Court in *Copperweld* rejected the type of "intra-enterprise" conspiracy theories advanced here. 467 U.S. at 769. Significantly, this Court in *Copperweld* explicitly disapproved of and overruled prior decisions to the contrary. 467 U.S. at 777.

In *Blue Shield of Massachusetts*, the First Circuit held that the Blue Shield defendant could not be considered merely a "sham" organization acting on behalf of the physician members, but was instead a legitimate "purchaser" of health care services from its members for its subscribers, and a legitimate indemnitor. 749 F.2d at 924-926, 932.

The Fourth Circuit, in *Cooper*, held that podiatrists had failed to establish a conspiracy, and hence that they could not prevail on their § 1 claims. Plaintiffs had charged a hospital with a "conspiracy" to deny them unrestricted privileges. Orthopedists, who by specialty perform services on the foot, generally competed with podiatrists, who were prohibited from performing certain services for the foot. 789 F.2d at 279. Orthopedists participated in hearings held by the hospital regarding changes in bylaws that would allow privileges to podiatrists. The bylaws committee, having heard the orthopedists' objections, recommended against changing the bylaws, and the hospital board accepted that recommendation, leaving bylaws which excluded podiatrists from privileges. 789 F.2d at 279-280. Following *Monsanto*, the Fourth Circuit held that this was not sufficient to find a conspiracy, citing, *inter alia*, other decisions in which courts had found plaintiff podiatrists

had failed to prove similar "conspiracy" theories. 789 F.2d at 281, citing, *Feldman v. Jackson Memorial Hospital*, 571 F. Supp. 1000, 1007 (S.D. Fla. 1983), *aff'd*, 752 F.2d 647 (11th Cir.), *cert. denied*, 472 U.S. 1029 (1985) (*"Feldman"*). The decision in *Feldman* holds that even orthopedists are not necessarily "competitors" of podiatrists where such orthopedists either do not practice privately, or do not practice in the areas in which the podiatrists practice. 571 F. Supp. at 1007 & nn. 11, 12. In short, even orthopedists, who are the medical doctors with whom podiatrists are most likely to compete directly, are not necessarily competitors with specific podiatrists, depending on private practice and specialty status, and therefore are not "co-conspirators" absent some evidence that they are in fact co-conspirators. To the contrary, here the Ninth Circuit presumes a conspiracy even absent competition with the plaintiffs.

The Sixth Circuit in *Potters* holds that a board member of a hospital cannot, as a matter of law, "conspire" with the hospital for purposes of the Sherman Act, stating it has never endorsed an "independent personal stake" "exception" suggested by other circuit court decisions, noting "rather substantial policy reasons for not adopting such an exception." 800 F.2d at 572-573. In *Oltz v. St. Peter's Community Hosp.*, 861 F.2d 1440, 1450 (9th Cir. 1988), the Ninth Circuit rejects *Potters* (and *Weiss v. York Hosp.*, 745 F.2d 786, 816-817 (3rd Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985)), and holds that a medical staff can conspire with a hospital (citing for support *Bolt v. Halifax Hosp. Medical Center*, 851 F.2d 1273, 1280 (11th Cir. 1988) [vacated, 861 F.2d 1233 (1988), reinstated in part pending rehearing, 1989-1 CCH Trade Cases ¶ 68,587 (1989) (en banc)]).

The Tenth Circuit in *McKenzie* recently held that physician plaintiffs' failure to identify co-conspirators was

fatal to plaintiffs' claims of conspiracy against a single health care service defendant. 854 F.2d at 367-368.

The Ninth Circuit's holding here allows the six individual podiatrist plaintiffs to proceed on a conspiracy theory without identifying a single co-conspirator--competitor or otherwise. The Ninth Circuit allows plaintiffs to proceed against OPS on a theory that OPS' own members somehow "conspired," relying upon a Fourth Circuit opinion in *Virginia Academy* that should be limited to its peculiar facts or overruled.

The Ninth Circuit holds that "so long as physicians * * * control the health care plan," plaintiffs may proceed, stating that is the "broad proposition" for which the decisions, including *Pennsylvania Blue Shield* stand. This holding is wrong: these decisions narrowly hold that if actual competitors (not just generic "physician") directly control the pricing and reimbursement (not just general management of the plan), plaintiffs may state a claim. The Ninth Circuit expansion to the contrary is not only unwarranted but dangerous.

The Ninth Circuit has rejected the analysis followed by the Sixth Circuit in *Potters*, and the result here is in conflict with the First Circuit's holding in *Blue Shield of Massachusetts*, the Fourth Circuit's decision in *Cooper*, the Tenth Circuit's holding in *McKenzie*, the Eleventh Circuit courts' holding in *Feldman*, and this Court's decisions in *Monsanto* and *Copperweld*. Accordingly, this Court should grant a writ of certiorari to review and reverse the Ninth Circuit decision here.

A.

There Cannot Be a "Horizontal" "Conspiracy" by OPS Here, Because OPS Does Not Compete With Plaintiffs, and the Ninth Circuit Result Here Is Contrary To Decisions by This Court and the First, Fifth, and Seventh Circuits Regarding Blue Shield Defendants in Texas, Massachusetts, and Indiana.

Even if OPS could be found to have "conspired" regarding podiatrists, the "conspiracy" would be "vertical," not horizontal. The six individual plaintiffs here did not sue individual physicians with whom they might be in "horizontal" competition, but instead sued the single corporate entity OPS.

The distinction is important, as recognized by this Court in *Group Life and Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979) (*"Blue Shield of Texas I"*), followed on remand by the Fifth Circuit in *Royal Drug Co. v. Group Life and Health Ins. Co.*, 737 F.2d 1433 (1984), *cert. denied*, 469 U.S. 1160 (1985) (*"Blue Shield of Texas II"*), and *Irving Ear, Nose, Throat & Allergy Clinic v. Group Hospital Service, Inc.*, 1985-2 CCH Trade Cases ¶ 66,849 (App. F), 776 F.2d 1046 (1985), *cert. denied*, 475 U.S. 1090 (1986) (*"Blue Shield of Texas III"*), and held by the First Circuit in *Blue Shield of Massachusetts*, and the Seventh Circuit in *Brillhart v. Mutual Medical Ins., Inc.*, 768 F.2d 196 (1985) (*"Blue Shield of Indiana"*).

In *Blue Shield of Texas II*, the Fifth Circuit, following this Court's decision in *Blue Shield of Texas I*, held that the alleged "conspiracy" by the Blue Shield defendant was not "horizontal." 737 F.2d at 1436-1437. Similarly, in *Blue Shield of Texas III*, the Fifth Circuit followed its decision in *Blue Shield of Texas II* and held

that plaintiffs did not compete with Blue Shield defendants, and there could be no horizontal restraint. Note 3, ¶ 68,849 at 64,217 (App. F at 59).

In *Blue Shield of Massachusetts*, the First Circuit cites the *Blue Shield of Texas I & II* decisions for its holding that the Blue Shield defendant was a single firm "purchaser" of services from its member physicians, serving as an indemnitor for its subscribers. 749 F.2d at 924. The First Circuit explicitly holds that because the Blue Shield defendant is a single firm, in vertical relationship with its physician members and subscribers, any alleged "conspiracy" against the plaintiff physicians must also be vertical, not horizontal, and no horizontal price-fixing could be involved. 749 F.2d at 930.

The Seventh Circuit, in *Blue Shield of Indiana*, following the decisions in *Blue Shield of Texas I & II* and *Blue Shield of Massachusetts*, likewise holds there is no "horizontal" restraint. 768 F.2d at 199.

The Ninth Circuit's treatment of the arrangement here as a "horizontal" "conspiracy" is in direct conflict with this Court's and the Fifth Circuit's decisions in *Blue Shield of Texas*, the First Circuit's in *Blue Shield of Massachusetts*, and the Seventh Circuit's in *Blue Shield of Indiana*. Accordingly, this Court should grant the writ of certiorari to review and reverse the Ninth Circuit's erroneous holdings to the contrary.

B.

The District Court Properly Applied Summary Judgment Standards in Determining That Plaintiffs Had Failed To Come Forward With Probative Evidence That There Was Any Conspiracy: The Ninth Circuit Reversal Based On the Mere Fact That Some Physicians Somewhere Might Compete With Podiatrists, and Other Physicians Were Members Of The Board of OPS, Is Contrary to Decisions From This Court and the Third, Fourth, Fifth, Seventh, Eighth, Tenth, and Eleventh Circuits.

As this Court held in *Monsanto*:

> "If an inference of such an agreement may be drawn from highly ambiguous evidence, there is a considerable danger that the doctrines enunciated in [*Continental T. V., Inc. v. GTE*] *Sylvania* [*Inc.* 433 U.S. 36 (1977)] and [*United States v.*] *Colgate* [*& Co.*, 250 U.S. 300 (1919)] will be seriously eroded.
>
> "The flaw in the evidentiary standard adopted by the Court of Appeals in this case is that it disregards this danger." 465 U.S. at 763-764 (citation and footnote omitted).

The Ninth Circuit erred by failing to require plaintiffs to come forward with evidence of a conspiracy. Although the panel deleted one egregious sentence from its first opinion, the second opinion still contains language reflecting an incorrect summary judgment standard, and still proceeds on the same incorrect analysis to determine that plaintiffs should be allowed to go to trial on an unfounded "inference" of a "walking conspiracy." In so doing, the Ninth Circuit panel decision conflicts with this Court's decision in *Monsanto*, the Third Circuit's decision in *Pennsylvania Blue Shield* and the Fifth Circuit's decision in *Consolidated Metal Prod. v.*

Amer. Petro. Institute, 846 F.2d 284, 293-294 (1982); this Court's summary judgment decisions in *Matsushita Elec. Industrial Co. v. Zenith Radio*, 475 U.S. 574 (1986) (*"Matsushita"*), *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242 (1986) (*"Anderson"*), and *Celotex Corp. v. Catrett*, 477 U.S. 317 (1986) (*"Celotex"*); and applications of the standards articulated there in antitrust health care conspiracy cases such as *White v. Rockingham Radiologists, Ltd.*, 820 F.2d 98, 101-103 (4th Cir. 1987) (*"White"*); *Collins v. Associated Pathologists, Ltd.*, 844 F.2d 473, 475 (7th Cir.), *cert. denied*, ___U.S.___, 109 S. Ct. 137, 102 L. Ed. 2d 110 (1988) (*"Collins"*); *Health Care Equalization Com. v. Iowa Medical Soc.*, 851 F.2d 1020, 1031-1032 (8th Cir. 1988) (*"Blue Shield of Iowa"*).

The Third Circuit has held that an antitrust defendant, such as OPS here, is not under any affirmative obligation to "prove" the absence of conspiracy. *Houser v. Fox Theatres Management Corp.*, 845 F.2d 1225, 1229, 1231 n.13 (1988) (*"Houser"*). The Tenth Circuit in *Dreiling v. Peugeot Motors of America, Inc.*, 850 F.2d 1373, 1379 n.3 (1988) (*"Dreiling"*), explicitly rejects the notion articulated by the Ninth Circuit here that a defendant's summary judgment should be reversed if plaintiffs "could" or "might" possibly adduce evidence to support their theories. In *Dunnivant v. Bi-State Auto Parts*, 851 F.2d 1575, 1579-1580 (1988) (*"Dunnivant"*), the Eleventh Circuit emphasizes that it is an antitrust plaintiffs' burden to present sufficient evidence to prove its case on defendant's motion for summary judgment. These decisions mark a reemphasis on the burden on an antitrust plaintiff to come forward with admissible evidence of a conspiracy, and the duty of a court not to indulge in inferences in favor of conspiracy absent significant proof tending to exclude an equally permissible inference of legitimate conduct. The Ninth

Circuit panel here refused to heed the proper summary judgment standard, leading to an erroneous result.

Not only did the Ninth Circuit fail to follow the proper summary judgment standards in evaluating the lack of evidence of conspiracy, but it erroneously embraced a "walking conspiracy" theory from the dated Fourth Circuit opinion in *Virginia Academy*, in conflict with rejections of just such a "walking conspiracy" theory by the Third Circuit in *Pennsylvania Blue Shield* and the Fifth Circuit in *Consolidated*.

The *Pennsylvania Blue Shield* case is particularly apt, because it too concerns charges of a "conspiracy" against a Blue Shield defendant. There, dentists charged that competing dentists comprised the majority of two committees of the board of the Blue Shield defendant. The Third Circuit rejected plaintiffs' "horizontal conspiracy with a vertical link" theory, noting that, as this Court had held in *Blue Shield of Texas I*, the Blue Shield defendant was merely a "purchaser" of services from dentists on behalf of its subscribers, and was an indemnitor for such services. 745 F.2d at 256-257. It specifically rejects application of the "walking conspiracy" theory of *Virginia Academy*. 745 F.2d at 257-258 & n.5. In particular, it holds that it is not enough to contend that members of the defendant Blue Shield might be able to compete with plaintiffs, because the court must look at whether actual competitors in the relevant market are involved. 745 F.2d at 258. This directly contradicts the holding by the Ninth Circuit here, where the mere possibility that some members of OPS might compete with some podiatrists somewhere was held sufficient. An "inference" of physician control cannot be enough here, not only because it is not reasonable on the record, but because the focus should be on whether competitors conspired against plaintiffs.

"Physicians" are not surrogates for "competitors," and mere physician membership on a board or committee is not a surrogate for "conspiracy." It is not reasonable to infer that because "physicians" were a majority of the board for a period of time, those "physicians" were "competitors" with "independent" economic motives who "conspired" against these individual plaintiff podiatrists with whom they did not compete. The bald statement that "physicians occupied a majority of the board seats supports at a minimum an inference that OPS is not an independent provider of health care," or "an inference that OPS is controlled by competitive providers" is simply not supportable. OPS is a "purchaser" and "indemnitor" reimbursing subscribers for services provided by physicians, including plaintiff podiatrists. Had the Ninth Circuit followed the Third Circuit's *Pennsylvania Blue Shield* test, it would have had to affirm the District Court's summary judgment here, which explicitly followed that Third Circuit test. The Fifth Circuit in *Consolidated* likewise rejects a "walking conspiracy" theory, and is likewise contrary to the Ninth Circuit decision here.

Because of the direct conflict here between the Third Circuit's rejection of the "walking conspiracy" on similar footing involving another Blue Shield defendant, the Ninth Circuit's rejection of the district court's application of that Third Circuit test, the Fifth Circuit's rejection of a similar "walking conspiracy" theory, and the Ninth Circuit's failure to follow the appropriate summary judgment standards articulated by this Court in *Anderson, Celotex,* and *Matsushita,* putting the Ninth Circuit decision in conflict with the decisions by the Third Circuit in *Houser,* the Fourth Circuit in *White,* the Seventh Circuit in *Collins,* the Eighth Circuit in *Blue Shield of Iowa,* the Tenth Circuit in *Dreiling*, and the Eleventh Circuit in *Dunnivant*, this Court should grant

the writ of certiorari to review and reject the Ninth Circuit's erroneous "inference" of a "walking conspiracy" theory.

II

Contrary to the Ninth Circuit Decision Here, Under Blue Shield Decisions From the First, Second, Third, and Seventh Circuits, This Court's Decision in *Maricopa* is Inapposite, and There Was No Price-Fixing Conspiracy.

The Ninth Circuit's approval of a "*per se*" price-fixing conspiracy theory here conflicts with the decisions by the First Circuit in *Blue Shield of Massachusetts*, the Second Circuit in *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc.*, 675 F.2d 502, 505 (2d Cir. 1982) (*"Blue Shield of Connecticut"*), the Third Circuit in *Pennsylvania Blue Shield,* and the Seventh Circuit in *Blue Shield of Indiana,* and constitutes an unwarranted mischaracterization and extension of this Court's decision in *Arizona v. Maricopa County Medical Society,* 457 U.S. 332 (1982) (*"Maricopa"*).

As noted already, the First Circuit in *Blue Shield of Massachusetts* rejected similar claims of "horizontal conspiracy." That included a claim of "*per se*" horizontal price-fixing. The First Circuit distinguished the *Maricopa* decision on the grounds that the Blue Shield defendant before it was a single firm regulated by the state, and under this Court's decision regarding a similar Blue Shield defendant in *Blue Shield of Texas I*, the defendant was not a "sham" organization of physicians forming a "horizontal" conspiracy. 749 F.2d at 924-926, 930.

In *Blue Shield of Connecticut,* the Second Circuit likewise follows this Court's decision in *Blue Shield of Texas I* to hold that a Blue Shield defendant was not engaged in horizontal price-fixing, again distinguishing

Maricopa as involving entirely different facts. 675 F.2d at 506. The Second Circuit notes that the Justice Department took the position that the Blue Shield type of arrangement was legal. 675 F.2d at 506 n.4.

Similarly, the Third Circuit in *Pennsylvania Blue Shield*, citing *Blue Shield of Connecticut,* holds that the Blue Shield arrangement does not constitute a per se price-fixing conspiracy, distinguishing the situation in *Maricopa*. The Third Circuit notes that this Court has not condemned vertical arrangements such as the Blue Shield one before it. 745 F.2d at 259.

Following *Blue Shield of Massachusetts* and *Blue Shield of Connecticut*, among other decisions, the Seventh Circuit in *Blue Shield of Indiana* likewise holds there was no price-fixing violation by the Blue Shield defendant. 768 F.2d at 199.

The District Court here properly found no evidence of conspiracy. Plaintiffs failed to produce evidence of any conspiracy. There is not even the suggestion that any physician, much less a member physician, agreed with anyone to have podiatrists reimbursed at a lesser absolute amount. To the contrary, the evidence was that podiatrists, including plaintiffs, could be reimbursed at amounts equal to or greater than any given physician, that plaintiffs in fact treated subscribers to OPS, and that OPS reimbursed at least a portion, if not all, of plaintiffs' fees for service to any given subscriber. OPS had a number of different policies, negotiated with its many different subscribers and subscriber groups. Some of those policies called for reimbursement of subscribers treated by nonmember health care providers at 100 percent, others called for reimbursement at 60 percent (and still others had other terms). Some of those policies called for payment to members only after certain

copayments, deductibles, and other charges had been paid, and the member agreements provided for a loss withhold in the event subscriber premiums did not cover the total outlay for payment and administrative costs. Hence members sometimes obtained less than 100 percent of their fee from OPS, and at least once in the past, the risk-withhold provisions had been exercised, and all members at that point received less than 100%, a risk not shared by nonmembers. There is no evidence of conspiracy of any sort, much less a "price-fixing" conspiracy. Each member physician was paid on the basis of that individual physician's independently determined fee for service. All that OPS did was to determine, for itself, that it would not generally pay for fees exceeding the 90th percentile of surveyed fees. In practice, that meant that each member physician was paid for each individual fee, whether that was at the 10th, 20th, 50th, 60th, 90th or other percentile. The evidence was that individual fees varied widely, and were reimbursed at widely varying rates.

Although the Ninth Circuit panel purports to follow *Maricopa*, its decision is inconsistent with this Court's decision for the reasons articulated by the First, Second, Third, and Seventh Circuits, and this Court should grant review.

A.
Plaintiffs Lack an Antitrust Leg to Stand on Here Because Their Patients Have Paid Them the "Balance Billing," and OPS Subscribers, Not Plaintiff Health Care Providers, Are the Only Ones Who Could Prosecute an Antitrust Action Under Blue Shield Decisions of This Court and the First Circuit

The Ninth Circuit erred by allowing plaintiffs to proceed without a showing of antitrust standing. This puts the

Ninth Circuit decision in conflict with this Court's decision in *Blue Shield of Virginia v. McCready,* 457 U.S. 465 (1982) (*"Blue Shield of Virginia"*), and the decision by the First Circuit in *Blue Shield of Massachusetts.*

As this Court held in *Blue Shield of Virginia,* health care provider plaintiffs such as those here lack standing to prosecute any antitrust action against Blue Shield defendants:

> "McCready has paid her psychologist's bill; her injury consists of Blue Shield's failure to pay her. Her psychologist can link no claim of injury to himself arising from his treatment of McCready; he has been fully paid for his service and has not been injured by Blue Shield's refusal to reimburse her for the cost of his services." 457 U.S. at 474-475 (footnote omitted; emphasis added).

The First Circuit's decision in *Blue Shield of Massachusetts* follows this approach regarding a "predatory pricing" claim, holding plaintiffs such as those here are "too remote" from any possible antitrust injury to be able to prosecute an antitrust action against a Blue Shield defendant. 749 F.2d at 933.

Because to allow these plaintiffs to proceed would conflict with this Court's decision in *Blue Shield of Virginia* and the First Circuit's in *Blue Shield of Massachusetts,* this Court should review and reverse the Ninth Circuit decisions here.

B.

In Any Event, as Held in Blue Shield Decisions From The First, Second, Third, Fifth, and Seventh Circuits, the "Vertical" Arrangement Here Should Not Be Condemned Under a "*Per Se*" Label.

The Ninth Circuit's suggestion that a "*per se*" theory was viable here is counter to this Court's admonition not to expand "*per se*" concepts beyond well-defined and limited bounds. *See, e.g., Business Electronics v. Sharp Electronics,* 485 U.S. 717, 108 S. Ct. 1515, 99 L. Ed. 2d 808 (1988). Unfortunately, the Ninth Circuit here traverses a number of pages discussing an inapplicable theory of price fixing, and even then fails to come to grips with the facts giving rise to this Court's decision in *Maricopa.* This failure leads to the fatally flawed conclusion that this case might fall within the prohibitions set forth there, and puts the Ninth Circuit decision here in conflict with the decisions by the First Circuit in *Blue Shield of Massachusetts*, the Second Circuit in *Blue Shield of Connecticut*, the Third Circuit in *Pennsylvania Blue Shield,* the Fifth Circuit in *Blue Shield of Texas II,* and the Seventh Circuit in *Blue Shield of Indiana,* that similar Blue Shield plans do not constitute "*per se*" violations.

In *Maricopa,* plaintiff State of Arizona sought only injunctive relief against agreements among competing physicians, set by majority vote, setting maximum fees. 457 U.S. at 336 & n.1. The two Foundation defendants were not insurers, indemnitors, or purchasers of services but were groups of physicians who established "relative value" and "conversion factor" schedules. 457 U.S. at 336-340. This Court identified an "insurer" as one who bears the risk of a subscriber needing services. 457 U.S. at 339 n.7. Speaking for four members of this Court, Justice Stevens noted that they were not concerned with

an insurer "fixing" prices at which it would reimburse physicians: the United States, in an amicus brief, had expressed the opinion that an insurer (such as a Blue Shield plan) could do so, with this Court specifically noting that "[w]e do not suggest that Blue Shield plans are not actually controlled by doctors," while stating that insurers could "fix" prices at which physicians would be reimbursed for services rendered to subscribers. 457 U.S. at 352-353 & n.26. Justice Stevens went further and noted that someone must canvass physicians' fees in order to determine what a reasonable price is. 457 U.S. at 353 n.28. On the facts before them, it was the physicians with market power who were jointly setting the fee schedules against the potential interest of the insurers, such as Blue Shield plans. See 457 U.S. at 354 & n.29. Neither of the two Foundation defendants could be considered a joint venture, or partnership, where the risks were on the venture: such a venture would be considered a single firm, not a conspiracy. 457 U.S. at 357. If such a single firm, such as a clinic, offered flat fee coverage, the cooperating doctors would have an arrangement in which price fixing agreements would be "perfectly proper." 457 U.S. at 357-358. (Justice Powell, writing in dissent for Chief Justice Burger and Justice Rehnquist, argued essentially that there were many pro-competitive features to the challenged arrangement, 457 U.S. at 358-367, and Justices Blackmun and O'Connor did not participate.)

The case under review here is such a plan, where the participating physicians share the risk through a withhold agreement in a corporate enterprise, where nonphysicians manage and operate the health care policies, and where the state of Oregon supervises and regulates OPS. OPS is a corporation operating as an "insurer," and as with a joint venture or partnership, it

would be "perfectly proper" for it to "fix" the price at which physicians will be reimbursed.

The Ninth Circuit's attempt to expand liability beyond that found by this Court in *Maricopa* led to its addition of footnote 5 to the amended opinion. That Ninth Circuit footnote would require a defendant to prove not just that it was a single integrated economic unit, but further that risk capital had been invested and individual members shared in "profit," and absent such proof by defendant, the arrangement is condemned as a "*per se*" violation. That Ninth Circuit requirement cannot be the law, and is contradicted by the following holding from this Court's decision in *Copperweld* that "such combinations are judged under a rule of reason, an inquiry into market power and market structure designed to assess the combination's actual effect." 467 U.S. at 768 (citations omitted).

The result reached in *Hassan v. Independent Practice Associates, P.C.*, 698 F. Supp. 679 (E.D. Mich. 1988) is illustrative. There, the defendant independent practice association ("IPA") was owned by the physicians who comprised the group. 698 F. Supp. at 681. There was a 12 percent "risk withhold," and occasions when payments had been delayed. 698 F. Supp. at 682. The board of directors for co-defendant HMO was made up of subscribers, the public, and physicians, but there was a dispute about the amount of control exercised by IPA and its physicians over co-defendant and its Board. Defendants there were able to avoid a *per se* price fixing charge because, among other reasons, the court determined that "[p]rice fixing agreements can be lawful if they are a necessary part of an integration of resources - a joint venture." 698 F. Supp. at 688. The court distinguished *Maricopa* as not involving an "insurer." 698 F. Supp. at 690. This result contradicts that reached by

the Ninth Circuit here. Similarly, the First Circuit in *Blue Shield of Massachusetts,* 749 F.2d at 931, the Second Circuit in *Blue Shield of Connecticut,* 675 F.2d at 505, the Third Circuit in *Pennsylvania Blue Shield,* 745 F.2d at 259-260, the Fifth Circuit in *Blue Shield of Texas II,* 737 F.2d at 1436-1437, and the Seventh Circuit in *Blue Shield of Indiana,* 768 F.2d at 199-200, hold similar Blue Shield plans do not constitute "*per se*" violations.

If the Ninth Circuit decision here is left standing, it would effectively negate any nonprofit arrangement such as the one here, because, by definition, members would not be able to share in "profit," and in many instances would not have invested capital, but instead "only" assumed risk that premiums would not cover payments. This would in essence eliminate one category of non-profit "health care service contractor" specifically sanctioned by the state of Oregon. ORS 750.005(2)(a) (App. M to petition No. 82-1773). The Ninth Circuit result here was neither contemplated nor intended by this Court in *Maricopa.* Although this Court used "profit-sharing" as but one example of the type of arrangement that was sufficiently integrated, that discussion in *Maricopa* should not be read to require all of the elements discussed in order for a health care defendant, such as the nonprofit corporation here, to be considered sufficiently "integrated." To so read it as does the Ninth Circuit here would denigrate state laws that allow just such corporations to operate.

Because the Ninth Circuit decision here conflicts with the decisions by the First Circuit in *Blue Shield of Massachusetts,* the Second Circuit in *Blue Shield of Connecticut,* the Third Circuit in *Pennsylvania Blue Shield,* the Fifth Circuit in *Blue Shield of Texas II,* and the Seventh Circuit in *Blue Shield of Indiana,* the district court decision in *Hassan,* and this Court's decision in

Maricopa, this Court should grant the writ to review and reverse the erroneous determination by the Ninth Circuit.

III.
There Is No "Group Boycott" Here, Where There Is No Conspiracy, Oregon State Statutes Differentiate Between Plaintiffs and Other Health Care Providers, OPS Was Concerned About "Overutilization" by Health Care Providers Like Plaintiffs, and the Ninth Circuit Result Here is Contrary to Blue Shield Decisions From the First, Third, and Fifth Circuits, and This Court's Decision Reversing a Previous Ninth Circuit Decision.

The only arguably appropriate theory advanced by plaintiffs here is "group boycott" (although, as even the Ninth Circuit apparently acknowledged, this claim is probably more accurately analysed as a "refusal to deal"). But then plaintiffs' real complaint is that they were not allowed to be part of the "price fixing conspiracy:" now that they are participating health care providers (in successor Blue Cross and Blue Shield of Oregon), their only argument can be that they were somehow improperly prohibited from participating sooner.

For the reasons already advanced, plaintiffs have failed to come forward with evidence that there was any "conspiracy," much less one among "competitors" directed at them. As set forth before, OPS was not under any affirmative obligation to "prove" that there was no conspiracy. *E.g., Houser*, 845 F.2d at 1229, 1231 n.13 (3d Cir. 1988). Nonetheless, OPS came forward with a number of proper justifications for its conduct, including the fact that the non-physician staff personnel who were responsible for the operation of the system felt that there were significant concerns regarding overutilization of podiatric services. There is no evidence that any

competitor of plaintiffs, physician or otherwise, influenced any decision by OPS to include or exclude podiatrists. The "scintilla" of evidence produced by plaintiffs and to which the Ninth Circuit opinion alludes involved a proposal to include a number of categories of providers as participants, where a non-physician board member (Ms. Gamble) was the one who suggested that only optometrists be admitted at that time. That is hardly "evidence" of a conspiracy by competitors to improperly exclude podiatrists, much less the substantial evidence tending to exclude the inference of proper conduct by OPS which plaintiffs must produce under this Court's recent summary judgment decisions. Furthermore, there was no "boycott" (or "refusal to deal"), because OPS in fact "dealt" with plaintiffs by reimbursing OPS subscribers for services rendered by plaintiffs. And plaintiffs were perfectly free to deal with other patients and insurers as well.

The Ninth Circuit decision conflicts with this Court's decision in *Northwest Stationers v. Pacific Stationery,* 472 U.S. 284 (1985) (*"Northwest"*), the First Circuit decision in *Blue Shield of Massachusetts,* the Third Circuit decision in *Pennsylvania Blue Shield,* the Fifth Circuit decision in *Blue Shield of Texas II,* and the Seventh Circuit's decision in *Moore v. Boating Industry Associations,* 819 F.2d 693, *cert. denied,* _ U.S. _, 108 S. Ct. 160, 98 L.Ed.2d 115 (1987).

In *Northwest,* this Court reversed a Ninth Circuit panel's decision that had injected a "fairness" doctrine into private antitrust boycott theory. In *Blue Shield of Massachusetts, Pennsylvania Blue Shield,* and *Blue Shield of Texas II,* the First, Third, and Fifth Circuits held that similar Blue Shield plans did not constitute an illegal "boycott." 749 F.2d at 932; 745 F.2d at 259-260; and 737 F.2d at 1433. In *Moore,* the Seventh Circuit, on remand

from this Court for review in light of *Northwest*, rejected a previous panel decision cited by plaintiffs here below, thereby rejecting various boycott theories advanced by plaintiffs here.

Because the Ninth Circuit opinions here conflict with this Court's previous reversal of a prior Ninth Circuit panel's attempt to import a "fairness" doctrine into private antitrust boycott theory, conflict with the decisions by the First, Third, and Fifth Circuits regarding similar Blue Shield plans, and conflict with the Seventh Circuit's rejection of similar boycott theories in *Moore*, this Court should grant the petition for a writ of certiorari to review and reverse the Ninth Circuit opinions.

A.

The Ninth Circuit Erroneously Allowed "Boycott" Theories Here Without Requiring Plaintiffs to Show Detrimental Effects or Market Power Where OPS Covers No More Than Sixteen Percent of Potential Subscribers, Contrary to This Court's Decision and the Seventh Circuit's Decision Regarding Blue Shield and Other Health Care Insurers of Indiana.

The Ninth Circuit's failure to require plaintiffs here to prove market power or detrimental effects conflicts with this Court's recent decision in *FTC v. Indiana Federation of Dentists,* 476 U.S. 447 (1986) (*"Indiana Federation of Dentists"*), and the Seventh Circuit's decision in *Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins.*, 784 F.2d 1325 (1986) (*"Blue Shield of Indiana II"*).

In *Indiana Federation of Dentists,* a case involving health care insurers in Indiana, this Court reaffirmed that generally a boycott case cannot proceed without a finding of market power, or actual detrimental effects on competition. 476 U.S. at 458, 460-461. In *Blue Shield of*

Indiana II, the Seventh Circuit discusses the importance of showing market power, there through a showing of market share. 784 F.2d at 1334-1338.

The Ninth Circuit here allowed plaintiffs to proceed without any showing of market power or actual detrimental effects, in conflict with this Court's decision reaffirming the requirement in *Indiana Federation of Dentists*, and the Seventh Circuit's emphasis in *Blue Shield of Indiana II*. On this ground, this Court should grant the writ to review and reverse this erroneous Ninth Circuit determination.

B.

The District Court Properly Found Plaintiffs Had Failed to Show Antitrust Injury, and the Ninth Circuit Erred by Allowing Plaintiffs to Proceed Without Such Showing, In Conflict With Blue Shield Decisions of the First and Fifth Circuits and Decisions of This Court and The Seventh Circuit.

Finally, the Ninth Circuit erred by allowing plaintiffs to proceed without a showing of injury to competition. This puts the Ninth Circuit decision in conflict with this Court's decision in *Brunswick*, and the decisions by the First Circuit in *Blue Shield of Massachusetts,* the Fifth Circuit in *Blue Shield of Texas III,* and the Seventh Circuit in *Zinser v. Rose*, 868 F.2d 938 (1989).

Not only do plaintiffs lack antitrust standing under this Court's decision in *Blue Shield of Virginia*, but they also lack "standing" because they failed to prove any injury to competition, as distinct from injury to themselves. Here, plaintiffs merely complain that they, themselves, may have lost some business. The Ninth Circuit panel ignored *Blue Shield of Texas III* (¶ 66,849

at 64,217 (App. F at 59-60)) and instead extends the *Virginia Academy* decision of the Fourth Circuit in allowing plaintiffs to proceed.

The First Circuit in *Blue Shield of Massachusetts*, like the Fifth Circuit in *Blue Shield of Texas III*, held that the health care provider plaintiffs there had failed to demonstrate antitrust injury as a result of the actions of the Blue Shield defendant, and the Seventh Circuit in *Zinser* similarly held that the health care provider plaintiffs there had failed to demonstrate antitrust injury with respect to comparable health care insurer defendants. *Accord Feldman*, 571 F. Supp. at 1009-1010.

In view of this conflict and because of support shown for the District Court's analysis in this Court's decision in *Brunswick*, and decisions in the First Circuit in *Blue Shield of Massachusetts*, the Fifth Circuit in *Blue Shield of Texas III*, the Seventh Circuit in *Zinser*, and the Eleventh Circuit in *Feldman*, this Court should grant certiorari to review and reject the Ninth Circuit panel's erroneous analysis.

CONCLUSION

For the foregoing reasons a writ of certiorari should be issued to review the judgment and opinions of the Court of Appeals for the Ninth Circuit.

Respectfully submitted,

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June 29, 1989

89-13

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JOSEPH F. SPANIOL, JR.
CLERK

No.

IN THE SUPREME COURT

OF THE UNITED STATES

OCTOBER TERM, 1988

OREGON PHYSICIANS' SERVICE,
an Oregon nonprofit corporation,

Petitioner,

v.

JOHN HAHN; WADE LIGGETT;
JOSEPH AIZAWA; V.G. LIVINGSTON;
HUGH FRASER; and HIDE AIZAWA,

Respondents.

APPENDIX TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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App. A

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

JOHN HAHN; WADE LIGGETT; JOSEPH AIZAWA; V.G. LIVINGSTON; HUGH FRASER; HIDE AIZAWA,	)	No. 87-3875
Plaintiffs-Appellants,	)	D.C. No. CV 78-0887 LE
v.	)	ORDER AND AMENDED OPINION
OREGON PHYSICIANS' SERVICE; PHYSICIANS' ASSOCIATION OF CLAKAMAS COUNTY,	)	
Defendants-Appellees.	)	

Appeal from the United States District Court
for the District of Oregon
Edward Leavy, District Judge, Presiding

Argued and Submitted
June 10, 1988 -- Portland, Oregon

Filed November 4, 1988
Amended February 27, 1989

Before: Procter Hug, Jr., Betty B. Fletcher and
Dorothy W. Nelson, Circuit Judges.

Opinion by Judge Fletcher

ORDER

The opinion filed November 4, 1988 and published at 860 F.2d 1501 (9th Cir. 1988) is amended as follows:

At page 13794 of the slip op. (860 F.2d at 1505), in the second paragraph of the section, STANDARD OF REVIEW, (1) insert before "*Barnes v. Arden Mayfair, Inc.*", "*Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 588 (1986)," (2) strike the last sentence of the paragraph.

At page 13800 of the slip opinion (860 F.2d at 1508), add the following as a new footnote, with the footnote call placed at the end of the second sentence in the second full paragraph (i.e. after the sentence that ends ". . . do not control the health care plan."):

> We recognize, however, that this rule may not be applicable to some health plans, such as health maintenance organizations, in which "persons who would otherwise be competitors pool their capital and share the risks of loss as well as the opportunities for profit. In such joint ventures, the partnership is regarded as a single firm competing with other sellers in the market." *Maricopa County*, 457 U.S. at 356. In such an arrangement, involving a "functionally integrated group of doctors," it is the doctors, rather than the patient or the insurer, who bear the economic risk. *Id.* at 339 n.7. Thus, for example, the Supreme Court has stated that "[i]f a clinic offered complete medical coverage for a flat fee, the cooperating doctors would have the type of partnership arrangement in which a price-fixing agreement among the doctors would be perfectly proper." *Id.* at 357. No such arrangement is present in this case.

At page 13802 of the slip opinion (860 F.2d at 1509), delete the second, third, and fourth sentences of the first full paragraph (i.e. the part beginning "Their evidence that physicians . . .") and substitute in their place the following:

> The appellants presented evidence by way of affidavit indicating that from 1975-81, physicians were responsible for 90% of foot care billings to OPS. This suggests that OPS member physicians are a significant competitive force in the Portland foot care market. Under these circumstances, we conclude that the appellants' evidence that physicians occupied a majority of the board seats supports an inference that OPS is controlled by competitive providers. In other words, the appellants have introduced sufficient evidence to permit a trier of fact to conclude that the OPS plan was, in fact, "an organization of physicians," *Barry*, 805 F.2d at 868, or an agent[ ] of [its] member physicians," *Virginia Academy*, 624 F.2d at 480. A trier of fact could reasonably conclude that the physician board members, even if not themselves competing directly with podiatrists, shared similar economic interests with those board members and OPS physicians who did compete directly, and that therefore the OPS board as a whole may have acted in the anticompetitive interests of those member physicians who compete with podiatrists for the provision of foot care.

At page 13806 of the slip opinion (860 F.2d at 1511), in the paragraph immediately preceding "CONCLUSION", delete line 5. The sentence as modified would read, "Whether ultimately the conduct can be sustained as justified or should be condemned, should be determined after a fully developed record at trial."

With these amendments, the panel has voted to deny the petition for rehearing. The full court has been advised of the suggestion for rehearing en banc and no active judge has requested a vote on whether to rehear the matter en banc. (Fed. R. App. P. 35)

The petition for rehearing is denied and the suggestion for rehearing en banc is rejected.

OPINION

FLETCHER, Circuit Judge:

Appellants appeal the district court's grant of summary judgment to appellees dismissing appellants' claim of violation of the Sherman Act, 15 U.S.C. § 1. We reverse and remand.

FACTS

Appellants are licensed doctors of podiatric medicine (D.P.M.'s) practicing in Oregon. Under state law, podiatrists are licensed to perform all foot procedures that medical doctors (M.D.'s) and doctors of osteopathic medicine (D.O.'s) may perform, except that they may not administer general or spinal anesthetics, or perform amputations. O.R.S. § 677.805(4).

Appellee Oregon Physicians' Service (OPS), founded by physicians, offers and administers a prepaid health care plan. At all relevant times, membership in OPS was limited to physicians and surgeons licensed to practice in Oregon. From 1974 to 1983, between 90 and 93 percent of all eligible M.D.'s and D.O.'s in Oregon were OPS members. In the same period, 16 percent of

the population of the Portland metropolitan area were subscribers.[1]

In the early 1970s, several of the appellants applied for membership in OPS, but were denied under OPS's policy of admitting only physicians. At that time, a majority of OPS's governing board of trustees were physicians. In 1982 the board contemplated extending membership to additional classes of providers, but decided to offer membership only to optometrists.

OPS offers many different policies to its subscribers, with varying terms. Under a majority of these policies, OPS offers a two-tier system covering health care costs. OPS conducts a survey of the fees for various services submitted to it by individual member physicians. Once the data has been compiled, the fees are referred to as the "usual, customary and reasonable" rates (UCR). OPS then determines the 90th percentile of such fees--that is, the rate at which 90 percent of the sample group charges the same or less.

When a member physician treats an OPS subscriber, OPS pays the physician directly up to the 90th percentile rate. The member physician must accept the OPS payment as payment in full and may not bill the subscriber for any extra amount. Nonmembers, on the other hand, may bill subscribers at whatever rate they choose. A subscriber pays a nonmember's bill and is then reimbursed by OPS, but generally at a rate no more than at the 60th percentile of the UCR. Nonmembers, unlike members, may bill subscribers for the balance of their fees. Appellants produced evidence that, on average,

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1 Although the parties may not be in complete agreement, appellants have apparently identified Portland as the proper geographic market for antitrust analysis.

OPS members received from OPS 76 cents on the dollar billed, while OPS paid podiatrists only 50 cents on the dollar billed. OPS subscribers were free to seek treatment from members or nonmembers as they wished.

In 1978, five of the appellants created the Fair Action Committee for Education, Inc. (FACE), a nonprofit corporation to which they assigned their antitrust claims against health care plans. FACE brought four separate antitrust actions against 12 prepaid health care plans in Oregon. In 1980, FACE was dissolved and the claims were reassigned to plaintiffs. Claims against five of the defendant health care plans were subsequently dismissed. The remaining seven defendants, including OPS, moved for summary judgment, alleging that their activity was exempt from the antitrust laws pursuant to the McCarran-Ferguson Act's exemption for the "business of insurance," 15 U.S.C. §§ 1011-1013, and arguing that plaintiffs had not shown sufficient impact on interstate commerce.

The district court granted defendants' motion for summary judgment. *Hahn v. Oregon Physicians' Serv.*, 508 F.Supp. 970 (D. Or. 1981). The Ninth Circuit reversed, holding that defendants' conduct was not exempted, but remanded for a finding as to the effect on interstate commerce. *Hahn v. Oregon Physicians' Serv.*, 689 F.2d 840 (9th Cir. 1982), *cert. denied*, 462 U.S. 1133 (1983). Appellants then settled with five of the remaining defendants.[2]

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[2] In 1983, OPS merged with Blue Cross of Oregon to form Blue Cross/Blue Shield of Oregon (BCBSO). As the survivor corporation, BCBSO expressly assumed all of OPS's rights, obligations and liabilities. In August 1985, BCBSO for the first time decided to allow podiatrists to become members. This later change in policy does not moot this action, however. *See Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 340 n.9 (1982).

In 1984, a trial was held on the impact of defendants' activities on interstate commerce. The district court found adequate impact to support federal antitrust jurisdiction. Appellants subsequently settled with the only remaining defendant other than OPS. On September 12, 1986, OPS moved for summary judgment. Appellants responded by moving for summary judgment in their favor or, in the alternative, for partial summary judgment. They also moved for leave to file an amended complaint naming BCBSO as defendant and appellants' professional corporations as plaintiffs.

On February 11, 1987, the district court granted summary judgment to OPS and denied all the motions appellants had filed in response. On April 24, appellants' motion to alter or amend the judgment was denied; the judgment dismissing their action was entered on May 1. Appellants timely appealed.

JURISDICTION

We assert jurisdiction over this appeal pursuant to 28 U.S.C. § 1291.

STANDARD OF REVIEW

We review a grant of summary judgment de novo, and will affirm if there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. *Barry v. Blue Cross of California*, 805 F.2d 866, 868 (9th Cir. 1986). Summary judgment is generally not favored in antitrust cases particularly because of their factual complexity, but it will be upheld if a plaintiff's complaint lacked any significant supporting evidence. *Klamath-Lake Pharm. Assoc. v. Klamath Med. Serv. Bureau*, 701 F.2d 1276, 1281-82 (9th Cir. 1983).

Where a plaintiff has alleged an illegal combination or conspiracy, a defendant seeking summary judgment has the burden of producing a plausible and justifiable explanation for its conduct that is consistent with proper business practices. Once the defendant has done so, the plaintiff must come forward with significant probative evidence capable of sustaining a reasonable inference that the defendant was not acting lawfully. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 588 (1986), *Barnes v. Arden Mayfair, Inc.*, 759 F.2d 676, 680 (9th Cir. 1985); *ALW, Inc. v. United Air Lines,* 510 F.2d 52, 55 (9th Cir. 1975).

DISCUSSION

Appellants argue that because they have adduced evidence that OPS was governed by a board controlled by physicians, that it expressly excluded non-physicians, and reimbursed nonmembers at a lower rate than members for the same services, they have made a prima facie case of a Section 1 violation.[3] Section 1 of the Sherman Act prohibits "[e]very contract, combination . . . or conspiracy, in restraint of trade." 15 U.S.C. § 1. To establish a section 1 violation, appellants must show three elements: (1) an agreement or conspiracy, (2) resulting in an unreasonable restraint of trade, and (3) causing antitrust injury. *Rickards v. Canine Eye Registration Fdn.*, 783 F.2d 1329, 1332 (9th Cir. 1986).

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3 In their original complaint, appellants raised claims under both 15 U.S.C. §§ 1 and 2, and the district court granted summary judgment under both sections. Appellants, however, state that they withdrew their section 2 claim shortly before OPS moved for summary judgment. They have not argued a section 2 theory on appeal. Brief of Appellants at 3 n.1.

Some practices are so likely to interfere with competition that courts have found them to be per se Sherman violations. The per se rule is invoked when a challenged activity facially appears to be one that would always or almost always tend to restrict competition and decrease output. *Id.*, citing *NCAA v. Board of Regents of Univ. of Okla.*, 468 U.S. 85, 100 (1984). Such practices include horizontal price-fixing, division of markets and certain group boycotts. *See, e.g., Northwest Wholesale Stationers v. Pacific Stationery*, 472 U.S. 284, 290 (1985) (group boycotts); *Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 343-45 (1982) (price-fixing); *United States v. Topco Associates, Inc.*, 405 U.S. 596, 608 (1972) (territorial market divisions).

Per se violations are a limited class, however, and it is much more common for courts to analyze questionable activities under the rule of reason. The rule of reason looks beyond the inherent anticompetitive potential of an activity and examines its actual effect in practice. It imposes on the plaintiff the burden of establishing that the practice in question unreasonably restrains competition. *Rickards*, 783 F.2d at 1333.

Since the effect on competition is the touchstone of rule of reason analysis, the intent of the defendants is relevant but not dispositive. *See NCAA*, 468 U.S. at 103; *Wilk v. AMA*, 719 F.2d 207, 225 (7th Cir. 1983). The existence of market power is a significant finding that casts an anticompetitive shadow over a party's practices in a rule-of-reason case. Ordinarily, it is an essential ingredient in a rule-of-reason case. Not so, however, where the conduct should be viewed as a per se violation. "[T]he absence of proof of market power does not justify a naked restriction on price or output." *NCAA*, 468 U.S. at 109.

Appellants allege that OPS's practices violate the Sherman Act in two ways: (1) as a horizontal price-fixing agreement; and (2) as a group boycott of podiatrists. Both such practices, they assert, constitute per se violations of Section 1. We address these claims in turn.

A. *Price Fixing.*

Appellants argue that by setting a fee schedule of maximum rates of reimbursement, OPS has engaged in horizontal price-fixing. They claim that OPS's two-tier reimbursement system forces them to compete on unfavorable terms with member physicians. OPS pays member physicians directly at the 90th percentile rate and bars them from charging subscribers any more. Nonmembers, by contrast, must bill subscribers, who are then reimbursed by OPS, but usually only at the 60th percentile rate. To subscribers, then, the services of member physicians are available at no cost beyond their subscription costs. The services of nonmembers, however, may be available to subscribers only at additional out-of-pocket cost to subscribers unless the nonmembers-podiatrists are willing to accept the rate at which OPS will reimburse as payment in full. Appellants contend OPS's billing and reimbursement practices have cost them both revenue and patients. Further, they claim they cannot compete with OPS members on these terms. Since OPS does not permit them to become members, the practices adversely affect competition.

In *Maricopa County*, 457 U.S. 332, member doctors of a medical society by agreement established maximum fees. The Maricopa Foundation operated similarly to OPS; it drew up a schedule of maximum fees, which participating doctors agreed to accept as payment in full for insured patients. *Id.* at 339. Insured patients were free to

go to nonmember physicians, but were obligated individually to pay any excess that nonmembers charged above the fee schedule. *Id.* at 341.

The Court found the practice to be a per se violation of Section 1. That the agreement was intended to set a ceiling on prices rather than a floor did not make it any the less price-fixing. "The *per se* rule 'is grounded on faith in price competition as a market force [and not] on a policy of low selling prices at the price of eliminating competition.' " *Id.* at 348 (citation omitted). The Court found particularly objectionable the fact that doctors who might otherwise have been in competition had made the agreement. "Even if a fee schedule is [ ] desirable, it is not necessary that the doctors do the price fixing," the Court observed, and distinguished by way of example another insurance program of the Maricopa Foundation that was administered by a state agency rather than by doctors. *Id.* at 352-53. The Court expressly stated that it was not deciding "whether an *insurer* may, consistent with the Sherman Act, fix the fee schedule and enter into bilateral contracts with individual doctors." *Id.* at 353 n.26 (emphasis added). The Court noted that it had also not reached the issue in *Group Life & Health Ins. v. Royal Drug Co.*, 440 U.S. 205 (1979). *Id.*

In *Royal Drug*, a group of independent pharmacists brought an antitrust action against Blue Shield of Texas for reimbursing subscribers at a higher rate when they bought from participating pharmacies than when they patronized non-participating pharmacies. Blue Shield had offered such an agreement to every pharmacy in the state. On remand from the Supreme Court, the Fifth Circuit answered the open question in the affirmative, distinguishing *Maricopa County* on the ground that the agreements did not run "between competitors in the pharmaceutical industry, nor between competitors in the

insurance industry, but between individual pharmacies and Blue Shield, which does not compete with pharmacies." *Royal Drug Co. v. Group Life & Health Ins.*, 737 F.2d 1433, 1436-37 (5th Cir. 1984). The court read *Maricopa County* not as a blanket condemnation of maximum medical fees, but as an affirmation that doctors may not, as *competitors*, horizontally enter into agreements to establish fees.

This circuit has agreed. In *Barry v. Blue Cross,* 805 F.2d 866, Blue Cross of California contracted with physicians to provide services to subscribers at a fixed rate to be set by Blue Cross. By statute, no more than one-third of Blue Cross's governing board could be physicians. Member physicians were reimbursed at 90 percent of the UCR, nonmembers at 60-70 percent. Both subscribers and members were free to deal with any patient, physician, or other insurer; the only restriction was that a member physician could not refer a subscriber to a nonmember without the subscriber's consent. *Id.* at 867-68.

We dismissed a Section 1 challenge to Blue Cross's practice. We did not consider *Maricopa County* controlling because we found no evidence to suggest that physicians controlled the Blue Cross plan; of the 126 members of various Blue Cross boards of directors, advisors, and senior staff, only 22 were physicians. *Id.* at 868-69. As a result, we found that the plan did not offend the antitrust laws under either a per se or a rule of reason analysis. *Id.* at 870.

The Fourth Circuit, however, applying a rule of reason analysis, held that the refusal of Blue Shield of Virginia to pay for services rendered by clinical psychologists unless they were billed through physicians violated the antitrust laws. *Virginia Acad. of Clinical Psychologists v. Blue Shield of Va.,* 624 F.2d 476 (4th Cir. 1980). Blue

Shield argued that its decision was unilateral, and that a corporation cannot conspire with itself under the anti-trust laws. Plaintiffs, on the other hand, contended that Blue Shield plans were nothing more than combinations of physicians. *Id.* at 479, 481. The court agreed with plaintiffs, finding that "in a real and legal sense, the Blue Shield Plans are agents of their member physicians." *Id.* at 480. Looking "at substance rather than form," the court held that since the bylaws of Blue Cross of Virginia required a majority of its board of directors to be physicians, there was sufficient physician control of the organization to make Blue Cross's restrictions on payments to clinical psychologists a violation of the Sherman Act.[4] *Id.* at 480-81.

In a case in which non-member dentists who considered themselves disadvantaged by a prepaid dental plan of Blue Shield challenged the plan, the Third Circuit looked to the influence of dentists over Blue Shield's policies, rather than to that of doctors. *Pennsylvania Dental Assoc. v. Medical Serv. Assoc. of Pa.*, 745 F.2d 248 (3d Cir. 1984). The plan was similar to the plans for doctors--member dentists agreed to accept a set percentage of the UCR as full payment for treating Blue Shield subscribers. A subscriber's payments to a non-member dentist would be reimbursed at the same rate, but the subscriber would be personally responsible for amounts charged above the UCR. *Id.* at 253.

The bylaws of Blue Shield provided for a board comprised of 16 lay persons and 16 doctors. Only two members of the 32 were dentists. *Id.* The Third Circuit held that to sustain its claim, the plaintiff would have to

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4 Although the decision in *Virginia Academy* predates *Maricopa County* by two years, the Fourth Circuit's opinion followed substantially similar reasoning.

show that member dentists, through their majority membership on two Blue Shield committees, actually controlled the UCR system. *Id.* at 256. Since it found that the committees were advisory only and real control was vested in the board, and since dentists accounted for only one-sixteenth of that body, the court upheld the district court's grant of summary judgment. *Id.* at 258-59. The court distinguished *Virginia Academy*, noting that the evidence in that case tended to show physician control. *Id.* at 257.

In the case before us, the district court granted summary judgment to OPS on the price-fixing claim on the ground that the majority of the OPS board, although physicians, did not compete economically with appellants for the provision of foot care in the relevant market. The court also found no evidence that any OPS members who did compete with appellant had conspired with OPS trustees. The court also ruled as a matter of law that under *Barry*, "health care plans like the OPS/BCBSO plan described here do not violate antitrust laws."

On the record before us, we cannot agree. Read together, *Maricopa County, Barry, Royal Drug, Virginia Academy* and *Pennsylvania Dental* stand for the broad proposition that health care plans may reimburse members and nonmembers differently, both in price and manner, so long as physicians (or the relevant group of competitive providers) do not control the health care plan.[5] In *Barry*, it was because the plaintiffs had failed to

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5 We recognize, however, that this rule may not be applicable to some health plans, such as health maintenance organizations, in which "persons who would otherwise be competitors pool their capital and share the risks of loss as well as the opportunities for profit. In such joint ventures, the partnership is regarded as a single firm competing with other sellers in

produce any evidence of physician control of the price-setting entity that we upheld the agreement as to prices and reimbursement. We fully recognized, however, that "a horizontal agreement among competing physicians . . . is per se unlawful under section 1" and *Maricopa*. *Barry*, 805 F.2d at 868. Likewise, *Royal Drug* upheld the challenged practice because it did not arise from an agreement "between *competitors*." *Royal Drug*, 737 F.2d at 1436 (emphasis added). Conversely, the *Virginia Academy* court did find proscribed activity where the health plans at issue were mere "agents of their member physicians." *Virginia Academy*, 624 F.2d at 480.

Based on the evidence plaintiffs have so far produced, their case is more akin to *Maricopa* than to *Barry*. They have shown, for instance, that physicians formed a majority of the board for many of the years in question.[6] They have also alleged that physicians who practice in any of 20 specialties perform procedures that podiatrists

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(Footnote 5 continued)

the market." *Maricopa County*, 457 U.S. at 356. In such an arrangement, involving a "functionally integrated group of doctors," it is the doctors, rather than the patient or the insurer, who bear the economic risk. *Id.* at 339 n.7. Thus, for example, the Supreme Court has stated that "[i]f a clinic offered complete medical coverage for a flat fee, the cooperating doctors would have the type of partnership arrangement in which a price-fixing agreement among the doctors would be perfectly proper." *Id.* at 357. No such arrangement is present in this case.

6 The district court found that a 1978 amendment to the OPS bylaws required 50 percent non-physician members on the OPS board.

perform.[7] Accordingly, many doctors are direct competitors to podiatrists, at least as to some of their services.

The district court stated that the majority of the OPS board did not, in fact, compete economically with the appellants in Portland. The court found that on a "typical" OPS board in the relevant years, a majority of trustees did not practice in Portland, and that many others had retired from practice. Accordingly, it concluded that a majority of trustees "would have no economic interest in restraining trade in the provision of foot care services in Portland."

Even if board members did not compete directly with the appellants, it cannot be determined as a matter of law that the board members had no economic interest in restraining trade. The proper inquiry is not whether individual board members *themselves* were in actual competition with the complaining nonmembers. Rather, the proper inquiry is whether practitioners sharing substantially similar economic interests collectively exercised control of a plan under whose auspices they have reached agreements which work to the detriment of competitors.

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7 The twenty listed specialties are: "(1) allergists, (2) anesthesiologists, (3) cardiovascular disease specialists and surgeons, (4) dermatologists, (5) endocrinologists, (6) family practitioners, (7) geriatric specialists, (7a) hematologists, (8) general practitioners, (9) diagnosis and internal medicine specialists, (10) infectious disease specialists, (10a) industrial practice specialists, (11) neurologists and neurosurgeons (12) oncologists, (13) orthopedic surgeons, (14) pathologists, (14a) physical medicine-rehabilitation specialists, (15) pediatricians, (16) plastic surgeons, (17) radiologists, (18) rheumatologists, (19) general surgeons, and (20) vascular surgeons." Brief of appellants, at 14.

See generally *Maricopa County*, 457 U.S. 332.[8] The challenged plan in *Barry* passed muster because it was "not an organization of physicians." *Barry*, 805 F.2d at 868. Similarly, the fact that physicians held half of the board seats in *Pennsylvania Dental* was irrelevant where the only potential competitors of the plaintiffs--dentists--held but two of 32 seats. Indeed, the *Pennsylvania Dental* court contrasted the dentists' negligible power with the physicians' controlling position in *Virginia Academy*. *Pennsylvania Dental*, 745 F.2d at 257.

Appellants in this case have made a sufficient factual showing to survive summary judgment. The appellants presented evidence by way of affidavit indicating that from 1975-81, physicians were responsible for 90% of foot care billings to OPS. This suggests that OPS member physicians are a significant competitive force in the Portland foot care market. Under these circumstances, we conclude that the appellants' evidence that physicians occupied a majority of the board seats supports an inference that OPS is controlled by competitive providers. In other words, the appellants have introduced sufficient evidence to permit a trier of fact to conclude that the OPS plan was, in fact, "an organization of physicians," *Barry*, 805 F.2d at 868, or an agent[ ] of [its] member physicians," *Virginia Academy*, 624 F.2d at 480. A trier of fact could reasonably conclude that the physician board members, even if not themselves competing directly with podiatrists, shared similar economic

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8 *See also Radiant Burners, Inc. v. Peoples Gas, Light & Coke Co.*, 364 U.S. 656, 657 n.1, 659-60 (1961) (though only six among "numerous" members of gas association directly competed with plaintiff, Sherman 1 claim was stated even in absence of proof that six direct competitors controlled association, because association members as a whole shared substantially similar economic interests).

interests with those board members and OPS physicians who did compete directly, and that therefore the OPS board as a whole may have acted in the anticompetitive interests of those member physicians who compete with podiatrists for the provision of foot care. The lack of evidence of an overt conspiracy is not dispositive. If the OPS plan was, in fact, a horizontal agreement among competitors, it was unlawful per se. *See Barry*, 805 F.2d at 868.

We conclude that, construing the evidence in the light most favorable to appellants, the district court acted precipitously in ruling as a matter of law that they were not entitled to judgment.

B. *Group Boycott*

Appellants also claim that they have made a prima facie showing that the exclusion of podiatrists from OPS, taken together with the discriminatory reimbursement policies for their services as non-members, constitutes a "group boycott" under Section 1.

Group boycotts, sometimes called concerted refusals to deal, commonly are considered business practices that merit per se invalidation under section 1. *Northwest Wholesale*, 472 U.S. at 290. However, the Supreme Court has cautioned lower courts not to be overinclusive in defining the categories of refusals to deal that amount to per se violations. "Cases to which this Court has applied the *per se* approach have generally involved joint efforts by a firm or firms to disadvantage competitors by 'either directly denying or persuading or coercing suppliers or customers to deny relationships the competitors need in the competitive struggle.' " *Id.* at 294, quoting L. Sullivan, Law of Antitrust 261-62 (1977).

Northwest Wholesale identified three characteristics as indicative of per se illegal boycotts: (1) the boycott cuts off access to a supply, facility, or market necessary to enable the victim firm to compete; (2) the boycotting firm possesses a dominant market position; and (3) the practices are not justified by plausible arguments that they enhanced overall efficiency or competition. *Id.* Under these or similar circumstances, the Court held, the danger of anticompetitive injury was sufficiently great that per se treatment was warranted. *Id.*[9]

In the absence of such a showing, however, the Court has since admonished that the category of activities comprising group boycotts "is not to be expanded indiscriminately." *FTC v. Indiana Federation of Dentists,* 476 U.S. 447, 458 (1986). Of particular relevance to this case, the Court added: "Moreover, we have been slow to condemn rules adopted by professional associations as unreasonable *per se* . . . and, in general, to extend *per se* analysis to restraints imposed in the context of business relationships where the economic impact of certain practices is not immediately obvious." *Id.* at 458-59.

However, the Court has not evidenced a similar reluctance to apply a rule of reason analysis to strike down rules of professional associations. In *Indiana Federation of Dentists*, the dentists formed a federation to continue the Indiana Dental Association's former policy of refusing to submit x-rays to dental health insurers with dental claim forms. Insurers requested the x-rays so that their administrators could determine whether the recommended course of treatment was reasonable. Applying a

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9 The Court's approach seems to suggest that the facts be developed as in a rule of reason case, or at least almost as fully, in order to determine whether the conduct is per se illegal.

rule of reason test, the Court ruled that the Federation's practice violated the antitrust laws.

Barry is instructive on the approach in this circuit to group boycott claims against professional organizations. The court applied rule of reason analysis to determine the effect on competition of Blue Cross's agreement with physicians. The *Barry* plaintiffs argued that the Blue Cross plan had the effect of boycotting nonmember physicians by interfering with their access to subscribers. Since nonmember services were reimbursed at a lower rate, the difference to be paid by the individual patient, they contended, few patients would consent to referral to a nonmember; this was tantamount to a refusal to deal. We rejected this argument, reasoning that the diversion of patients from other physicians was little different from

> the ordinary consequence of every commercial contract . . . When a consumer contracts to buy services from one health plan, the consumer will then have little or no demand for the services of a nonparticipating physician, especially if the consumer would have to pay more for those services. The contract does not mean that the parties have agreed to an unlawful concerted refusal to deal.

Barry, 805 F.2d at 872. In upholding the practice, however, we took pains to distinguish *Virginia Academy*, in which there was also an allegation of boycott:

> [i]n that case, Blue Shield reimbursed for psychologists' services only when billed through a member physician. Psychiatrists, who compete with psychologists, did not face this obstacle because, as medical doctors, they could simply become members of Blue Shield. By contrast, in the present case, Blue Cross *does not discriminate* against a

particular class of medical provider, but instead is willing to purchase services from all physicians on equal terms.

Id. at 873 (emphasis added).

Obviously, the fact that OPS *does* discriminate against a class of providers distinguishes this case from *Barry*. While, standing alone, OPS's two-tier fee system could probably withstand a "boycott" challenge under *Barry*, when coupled with OPS's long refusal to admit podiatrists, it is doubtful whether OPS was, in fact, "willing to purchase services from all [practitioners] on equal terms." *Id.*

OPS has the burden under *Barnes* of putting forward a plausible, justifiable explanation for its conduct. It stipulated that it would "not defend this case in any way on the basis that the quality of health care provided by podiatrists is inferior to that provided by other providers of health care." Instead, it claims that "problems with podiatrist claims overutilization"[10] motivated its decision to exclude podiatrists from membership. Brief of Appellee at 9. Even if this is a plausible and legitimate basis for exclusion, we find that appellants sustained their burden under *Barnes* of raising a reasonable inference, grounded in evidence, to refute OPS's claimed justification. Again without deciding any factual issues, we note that the record includes testimony from a former OPS board member, Dr. Price, suggesting that the exclusion of podiatrists was prompted neither by considerations of cost nor by fears of overbilling. Appellants have also produced evidence that the overall costs for foot procedures

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10 It is unclear whether the contention is that patients sought unnecessary care or that podiatrists performed unnecessary procedures.

performed by podiatrists were lower than those of OPS members. *See* Reply Brief of Appellants at 13-14.

Viewing the evidence in the light most favorable to appellants, we must conclude that they are entitled to go to trial on their group boycott theory. Whether ultimately the conduct can be sustained as justified or should be condemned, should be determined after a fully developed record at trial. Summary judgment should not have been granted.

CONCLUSION

Appellants asked that we direct the district court to enter summary judgment in their favor. We conclude that genuine issues of material fact remain. In such a case that is rife with factual complexity, summary judgment for either side is rarely justified. *See Barnes*, 759 F.2d at 681. Accordingly, we decline appellants' invitation, reverse the summary judgment in favor of OPS and remand for trial.

REVERSED and REMANDED.

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

JOHN HAHN; WADE LIGGETT; JOSEPH AIZAWA; V.G. LIVINGSTON; HUGH FRASER; HIDE AIZAWA,	) No. 87-3875
Plaintiffs-Appellants,	) D.C. No. CV 78-0887 LE
v.	) OPINION
OREGON PHYSICIANS' SERVICE; PHYSICIANS' ASSOCIATION OF CLAKAMAS COUNTY,	)
Defendants-Appellees.	)

Appeal from the United States District Court
for the District of Oregon
Edward Leavy, District Judge, Presiding

Argued and Submitted
June 10, 1988 -- Portland, Oregon

Filed November 4, 1988

Before: Procter Hug, Jr., Betty B. Fletcher and Dorothy W. Nelson, Circuit Judges.

Opinion by Judge Fletcher

OPINION

FLETCHER, Circuit Judge:

Appellants appeal the district court's grant of summary judgment to appellees dismissing appellants' claim of violation of the Sherman Act, 15 U.S.C. § 1. We reverse and remand.

FACTS

Appellants are licensed doctors of podiatric medicine (D.P.M.'s) practicing in Oregon. Under state law, podiatrists are licensed to perform all foot procedures that medical doctors (M.D.'s) and doctors of osteopathic medicine (D.O.'s) may perform, except that they may not administer general or spinal anesthetics, or perform amputations. O.R.S. § 677.805(4).

Appellee Oregon Physicians' Service (OPS), founded by physicians, offers and administers a prepaid health care plan. At all relevant times, membership in OPS was limited to physicians and surgeons licensed to practice in Oregon. From 1974 to 1983, between 90 and 93 percent of all eligible M.D.'s and D.O.'s in Oregon were OPS members. In the same period, 16 percent of the population of the Portland metropolitan area were subscribers.[1]

In the early 1970s, several of the appellants applied for membership in OPS, but were denied under OPS's policy of admitting only physicians. At that time, a majority of OPS's governing board of trustees were physi-

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[1] Although the parties may not be in complete agreement, appellants have apparently identified Portland as the proper geographic market for antitrust analysis.

cians. In 1982 the board contemplated extending membership to additional classes of providers, but decided to offer membership only to optometrists.

OPS offers many different policies to its subscribers, with varying terms. Under a majority of these policies, OPS offers a two-tier system covering health care costs. OPS conducts a survey of the fees for various services submitted to it by individual member physicians. Once the data has been compiled, the fees are referred to as the "usual, customary and reasonable" rates (UCR). OPS then determines the 90th percentile of such fees--that is, the rate at which 90 percent of the sample group charges the same or less.

When a member physician treats an OPS subscriber, OPS pays the physician directly up to the 90th percentile rate. The member physician must accept the OPS payment as payment in full and may not bill the subscriber for any extra amount. Nonmembers, on the other hand, may bill subscribers at whatever rate they choose. A subscriber pays a nonmember's bill and is then reimbursed by OPS, but generally at a rate no more than at the 60th percentile of the UCR. Nonmembers, unlike members, may bill subscribers for the balance of their fees. Appellants produced evidence that, on average, OPS members received from OPS 76 cents on the dollar billed, while OPS paid podiatrists only 50 cents on the dollar billed. OPS subscribers were free to seek treatment from members or nonmembers as they wished.

In 1978, five of the appellants created the Fair Action Committee for Education, Inc. (FACE), a nonprofit corporation to which they assigned their antitrust claims against health care plans. FACE brought four separate antitrust actions against 12 prepaid health care

plans in Oregon. In 1980, FACE was dissolved and the claims were reassigned to plaintiffs. Claims against five of the defendant health care plans were subsequently dismissed. The remaining seven defendants, including OPS, moved for summary judgment, alleging that their activity was exempt from the antitrust laws pursuant to the McCarran-Ferguson Act's exemption for the "business of insurance," 15 U.S.C. §§ 1011-1013, and arguing that plaintiffs had not shown sufficient impact on interstate commerce.

The district court granted defendants' motion for summary judgment. *Hahn v. Oregon Physicians' Serv.*, 508 F.Supp. 970 (D. Or. 1981). The Ninth Circuit reversed, holding that defendants' conduct was not exempted, but remanded for a finding as to the effect on interstate commerce. *Hahn v. Oregon Physicians' Serv.*, 689 F.2d 840 (9th Cir. 1982), *cert. denied*, 462 U.S. 1133 (1983). Appellants then settled with five of the remaining defendants.[2]

In 1984, a trial was held on the impact of defendants' activities on interstate commerce. The district court found adequate impact to support federal antitrust jurisdiction. Appellants subsequently settled with the only remaining defendant other than OPS. On September 12, 1986, OPS moved for summary judgment. Appellants responded by moving for summary judgment in their favor or, in the alternative, for partial summary

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2 In 1983, OPS merged with Blue Cross of Oregon to form Blue Cross/Blue Shield of Oregon (BCBSO). As the survivor corporation, BCBSO expressly assumed all of OPS's rights, obligations and liabilities. In August 1985, BCBSO for the first time decided to allow podiatrists to become members. This later change in policy does not moot this action, however. *See Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 340 n.9 (1982).

judgment. They also moved for leave to file an amended complaint naming BCBSO as defendant and appellants' professional corporations as plaintiffs.

On February 11, 1987, the district court granted summary judgment to OPS and denied all the motions appellants had filed in response. On April 24, appellants' motion to alter or amend the judgment was denied; the judgment dismissing their action was entered on May 1. Appellants timely appealed.

JURISDICTION

We assert jurisdiction over this appeal pursuant to 28 U.S.C. § 1291.

STANDARD OF REVIEW

We review a grant of summary judgment de novo, and will affirm if there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. *Barry v. Blue Cross of California*, 805 F.2d 866, 868 (9th Cir. 1986). Summary judgment is generally not favored in antitrust cases particularly because of their factual complexity, but it will be upheld if a plaintiff's complaint lacked any significant supporting evidence. *Klamath-Lake Pharm. Assoc. v. Klamath Med. Serv. Bureau*, 701 F.2d 1276, 1281-82 (9th Cir. 1983).

Where a plaintiff has alleged an illegal combination or conspiracy, a defendant seeking summary judgment has the burden of producing a plausible and justifiable explanation for its conduct that is consistent with proper business practices. Once the defendant has done so, the plaintiff must come forward with significant probative evidence capable of sustaining a reasonable inference that the defendant was not acting lawfully. *Barnes v.*

Arden Mayfair, Inc., 759 F.2d 676, 680 (9th Cir. 1985); *ALW, Inc. v. United Air Lines*, 510 F.2d 52, 55 (9th Cir. 1975). If the evidence could support both an inference of conspiracy and one of lawful conduct, summary judgment is inappropriate. *Barnes*, 759 F.2d at 681.

DISCUSSION

Appellants argue that because they have adduced evidence that OPS was governed by a board controlled by physicians, that it expressly excluded non-physicians, and reimbursed nonmembers at a lower rate than members for the same services, they have made a prima facie case of a Section 1 violation.[3] Section 1 of the Sherman Act prohibits "[e]very contract, combination . . . or conspiracy, in restraint of trade." 15 U.S.C. § 1. To establish a section 1 violation, appellants must show three elements: (1) an agreement or conspiracy, (2) resulting in an unreasonable restraint of trade, and (3) causing antitrust injury. *Rickards v. Canine Eye Registration Fdn.*, 783 F.2d 1329, 1332 (9th Cir. 1986).

Some practices are so likely to interfere with competition that courts have found them to be per se Sherman violations. The per se rule is invoked when a challenged activity facially appears to be one that would always or almost always tend to restrict competition and decrease output. *Id.*, citing *NCAA v. Board of Regents of*

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3 In their original complaint, appellants raised claims under both 15 U.S.C. §§ 1 and 2, and the district court granted summary judgment under both sections. Appellants, however, state that they withdrew their section 2 claim shortly before OPS moved for summary judgment. They have not argued a section 2 theory on appeal. Brief of Appellants at 3 n.1.

Univ. of Okla., 468 U.S. 85, 100 (1984). Such practices include horizontal price-fixing, division of markets and certain group boycotts. *See, e.g., Northwest Wholesale Stationers v. Pacific Stationery*, 472 U.S. 284, 290 (1985) (group boycotts); *Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 343-45 (1982) (price-fixing); *United States v. Topco Associates, Inc.*, 405 U.S. 596, 608 (1972) (territorial market divisions).

Per se violations are a limited class, however, and it is much more common for courts to analyze questionable activities under the rule of reason. The rule of reason looks beyond the inherent anticompetitive potential of an activity and examines its actual effect in practice. It imposes on the plaintiff the burden of establishing that the practice in question unreasonably restrains competition. *Rickards*, 783 F.2d at 1333.

Since the effect on competition is the touchstone of rule of reason analysis, the intent of the defendants is relevant but not dispositive. *See NCAA*, 468 U.S. at 103; *Wilk v. AMA*, 719 F.2d 207, 225 (7th Cir. 1983). The existence of market power is a significant finding that casts an anticompetitive shadow over a party's practices in a rule-of-reason case. Ordinarily, it is an essential ingredient in a rule-of-reason case. Not so, however, where the conduct should be viewed as a per se violation. "[T]he absence of proof of market power does not justify a naked restriction on price or output." *NCAA*, 468 U.S. at 109.

Appellants allege that OPS's practices violate the Sherman Act in two ways: (1) as a horizontal price-fixing agreement; and (2) as a group boycott of podiatrists. Both such practices, they assert, constitute per se violations of Section 1. We address these claims in turn.

A. *Price Fixing.*

Appellants argue that by setting a fee schedule of maximum rates of reimbursement, OPS has engaged in horizontal price-fixing. They claim that OPS's two-tier reimbursement system forces them to compete on unfavorable terms with member physicians. OPS pays member physicians directly at the 90th percentile rate and bars them from charging subscribers any more. Nonmembers, by contrast, must bill subscribers, who are then reimbursed by OPS, but usually only at the 60th percentile rate. To subscribers, then, the services of member physicians are available at no cost beyond their subscription costs. The services of nonmembers, however, may be available to subscribers only at additional out-of-pocket cost to subscribers unless the nonmember-podiatrists are willing to accept the rate at which OPS will reimburse as payment in full. Appellants contend OPS's billing and reimbursement practices have cost them both revenue and patients. Further, they claim they cannot compete with OPS members on these terms. Since OPS does not permit them to become members, the practices adversely affect competition.

In *Maricopa County*, 457 U.S. 332, member doctors of a medical society by agreement established maximum fees. The Maricopa Foundation operated similarly to OPS; it drew up a schedule of maximum fees, which participating doctors agreed to accept as payment in full for insured patients. *Id.* at 339. Insured patients were free to go to nonmember physicians, but were obligated individually to pay any excess that nonmembers charged above the fee schedule. *Id.* at 341.

The Court found the practice to be a per se violation of Section 1. That the agreement was intended to set

a ceiling on prices rather than a floor did not make it any the less price-fixing. "The *per se* rule 'is grounded on faith in price competition as a market force [and not] on a policy of low selling prices at the price of eliminating competition.' " *Id.* at 348 (citation omitted). The Court found particularly objectionable the fact that doctors who might otherwise have been in competition had made the agreement. "Even if a fee schedule is [ ] desirable, it is not necessary that the doctors do the price fixing," the Court observed, and distinguished by way of example another insurance program of the Maricopa Foundation that was administered by a state agency rather than by doctors. *Id.* at 352-53. The Court expressly stated that it was not deciding "whether an *insurer* may, consistent with the Sherman Act, fix the fee schedule and enter into bilateral contracts with individual doctors." *Id.* at 353 n.26 (emphasis added). The Court noted that it had also not reached the issue in *Group Life & Health Ins. v. Royal Drug Co.*, 440 U.S. 205 (1979). *Id.*

In *Royal Drug*, a group of independent pharmacists brought an antitrust action against Blue Shield of Texas for reimbursing subscribers at a higher rate when they bought from participating pharmacies than when they patronized non-participating pharmacies. Blue Shield had offered such an agreement to every pharmacy in the state. On remand from the Supreme Court, the Fifth Circuit answered the open question in the affirmative, distinguishing *Maricopa County* on the ground that the agreements did not run "between competitors in the pharmaceutical industry, nor between competitors in the insurance industry, but between individual pharmacies and Blue Shield, which does not compete with pharmacies." *Royal Drug Co. v. Group Life & Health Ins.*, 737 F.2d 1433, 1436-37 (5th Cir. 1984). The court read *Maricopa County* not as a blanket condemnation of maximum

medical fees, but as an affirmation that doctors may not, as *competitors*, horizontally enter into agreements to establish fees.

This circuit has agreed. In *Barry v. Blue Cross*, 805 F.2d 866, Blue Cross of California contracted with physicians to provide services to subscribers at a fixed rate to be set by Blue Cross. By statute, no more than one-third of Blue Cross's governing board could be physicians. Member physicians were reimbursed at 90 percent of the UCR, nonmembers at 60-70 percent. Both subscribers and members were free to deal with any patient, physician, or other insurer; the only restriction was that a member physician could not refer a subscriber to a nonmember without the subscriber's consent. *Id.* at 867-68.

We dismissed a Section 1 challenge to Blue Cross's practice. We did not consider *Maricopa County* controlling because we found no evidence to suggest that physicians controlled the Blue Cross plan; of the 126 members of various Blue Cross boards of directors, advisors, and senior staff, only 22 were physicians. *Id.* at 868-69. As a result, we found that the plan did not offend the antitrust laws under either a per se or a rule of reason analysis. *Id.* at 870.

The Fourth Circuit, however, applying a rule of reason analysis, held that the refusal of Blue Shield of Virginia to pay for services rendered by clinical psychologists unless they were billed through physicians violated the antitrust laws. *Virginia Acad. of Clinical Psychologists v. Blue Shield of Va.*, 624 F.2d 476 (4th Cir. 1980). Blue Shield argued that its decision was unilateral, and that a corporation cannot conspire with itself under the antitrust laws. Plaintiffs, on the other hand, contended that Blue Shield plans were nothing more than combinations

of physicians. *Id.* at 479, 481. The court agreed with plaintiffs, finding that "in a real and legal sense, the Blue Shield Plans are agents of their member physicians." *Id.* at 480. Looking "at substance rather than form," the court held that since the bylaws of Blue Cross of Virginia required a majority of its board of directors to be physicians, there was sufficient physician control of the organization to make Blue Cross's restrictions on payments to clinical psychologists a violation of the Sherman Act.[4] *Id.* at 480-81.

In a case in which non-member dentists who considered themselves disadvantaged by a prepaid dental plan of Blue Shield challenged the plan, the Third Circuit looked to the influence of dentists over Blue Shield's policies, rather than to that of doctors. *Pennsylvania Dental Assoc. v. Medical Serv. Assoc. of Pa.*, 745 F.2d 248 (3d Cir. 1984). The plan was similar to the plans for doctors--member dentists agreed to accept a set percentage of the UCR as full payment for treating Blue Shield subscribers. A subscriber's payments to a non-member dentist would be reimbursed at the same rate, but the subscriber would be personally responsible for amounts charged above the UCR. *Id.* at 253.

The bylaws of Blue Shield provided for a board comprised of 16 lay persons and 16 doctors. Only two members of the 32 were dentists. *Id.* The Third Circuit held that to sustain its claim, the plaintiff would have to show that member dentists, through their majority membership on two Blue Shield committees, actually controlled the UCR system. *Id.* at 256. Since it found that the committees were advisory only and real control was vested in the board, and since dentists accounted for only

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[4] Although the decision in *Virginia Academy* predates *Maricopa County* by two years, the Fourth Circuit's opinion followed substantially similar reasoning.

one-sixteenth of that body, the court upheld the district court's grant of summary judgment. *Id.* at 258-59. The court distinguished *Virginia Academy*, noting that the evidence in that case tended to show physician control. *Id.* at 257.

In the case before us, the district court granted summary judgment to OPS on the price-fixing claim on the ground that the majority of the OPS board, although physicians, did not compete economically with appellants for the provision of foot care in the relevant market. The court also found no evidence that any OPS members who did compete with appellant had conspired with OPS trustees. The court also ruled as a matter of law that under *Barry*, "health care plans like the OPS/BCBSO plan described here do not violate antitrust laws."

On the record before us, we cannot agree. Read together, *Maricopa County, Barry, Royal Drug, Virginia Academy* and *Pennsylvania Dental* stand for the broad proposition that health care plans may reimburse members and nonmembers differently, both in price and manner, so long as physicians (or the relevant group of competitive providers) do not control the health care plan. In *Barry*, it was because the plaintiffs had failed to produce any evidence of physician control of the price-setting entity that we upheld the agreement as to prices and reimbursement. We fully recognized, however, that "a horizontal agreement among competing physicians . . . is per se unlawful under section 1" and *Maricopa*. *Barry*, 805 F.2d at 868. Likewise, *Royal Drug* upheld the challenged practice because it did not arise from an agreement "between *competitors*." *Royal Drug*, 737 F.2d at 1436 (emphasis added). Conversely, the *Virginia Academy* court did find proscribed activity where the health plans at issue were mere "agents of their member physicians." *Virginia Academy*, 624 F.2d at 480.

Based on the evidence plaintiffs have so far produced, their case is more akin to *Maricopa* than to *Barry*. They have shown, for instance, that physicians formed a majority of the board for many of the years in question.[5] They have also alleged that physicians who practice in any of 20 specialties perform procedures that podiatrists perform.[6] Accordingly, many doctors are direct competitors to podiatrists, at least as to some of their services.

The district court stated that the majority of the OPS board did not, in fact, compete economically with the appellants in Portland. The court found that on a "typical" OPS board in the relevant years, a majority of trustees did not practice in Portland, and that many others had retired from practice. Accordingly, it concluded that a majority of trustees "would have no economic interest in restraining trade in the provision of foot care services in Portland."

Even if board members did not compete directly with the appellants, it cannot be determined as a matter

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5 The district court found that a 1978 amendment to the OPS bylaws required 50 percent non-physician members on the OPS board.

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6 The twenty listed specialties are: "(1) allergists, (2) anesthesiologists, (3) cardiovascular disease specialists and surgeons, (4) dermatologists, (5) endocrinologists, (6) family practitioners, (7) geriatric specialists, (7a) hematologists, (8) general practitioners, (9) diagnosis and internal medicine specialists, (10) infectious disease specialists, (10a) industrial practice specialists, (11) neurologists and neurosurgeons (12) oncologists, (13) orthopedic surgeons, (14) pathologists, (14a) physical medicine-rehabilitation specialists, (15) pediatricians, (16) plastic surgeons, (17) radiologists, (18) rheumatologists, (19) general surgeons, and (20) vascular surgeons." Brief of appellants, at 14.

of law that the board members had no economic interest in restraining trade. The proper inquiry is not whether individual board members *themselves* were in actual competition with the complaining nonmembers. Rather, the proper inquiry is whether practitioners sharing substantially similar economic interests collectively exercised control of a plan under whose auspices they have reached agreements which work to the detriment of competitors. *See* generally *Maricopa County*, 457 U.S. 332.[7] The challenged plan in *Barry* passed muster because it was "not an organization of physicians." *Barry*, 805 F.2d at 868. Similarly, the fact that physicians held half of the board seats in *Pennsylvania Dental* was irrelevant where the only potential competitors of the plaintiffs--dentists--held but two of 32 seats. Indeed, the *Pennsylvania Dental* court contrasted the dentists' negligible power with the physicians' controlling position in *Virginia Academy*. *Pennsylvania Dental*, 745 F.2d at 257.

Appellants in this case have made a sufficient factual showing to survive summary judgment. Their evidence that physicians occupied a majority of the board seats supports at a minimum an inference that OPS is not an independent provider of health care. In other words, evidence might well be produced at trial that would cause a trier-of-fact to conclude that the OPS plan was, in fact, "an organization of physicians," *Barry*, 805 F.2d at 868, or an "agent[ ] of [its] member physicians," *Virginia Academy*, 624 F.2d at 480. Board members, even if not com-

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7 *See also Radiant Burners, Inc. v. Peoples Gas, Light & Coke Co.*, 364 U.S. 656, 657 n.1, 659-60 (1961) (though only six among "numerous" members of gas association directly competed with plaintiff, Sherman 1 claim was stated even in absence of proof that six direct competitors controlled association, because association members as a whole shared substantially similar economic interests).

peting directly with podiatrists, may have acted in their joint and reciprocal self-interest to approve a price-fixing agreement among those fellow physicians who did compete directly. The lack of evidence of an overt conspiracy is not dispositive. If the OPS plan was, in fact, a horizontal agreement among competitors, it was unlawful per se. *See Barry*, 805 F.2d at 868.

We conclude that, construing the evidence in the light most favorable to appellants, the district court acted precipitously in ruling as a matter of law that they were not entitled to judgment.

B. *Group Boycott*

Appellants also claim that they have made a prima facie showing that the exclusion of podiatrists from OPS, taken together with the discriminatory reimbursement policies for their services as non-members, constitutes a "group boycott" under Section 1.

Group boycotts, sometimes called concerted refusals to deal, commonly are considered business practices that merit per se invalidation under section 1. *Northwest Wholesale*, 472 U.S. at 290. However, the Supreme Court has cautioned lower courts not to be overinclusive in defining the categories of refusals to deal that amount to per se violations. "Cases to which this Court has applied the *per se* approach have generally involved joint efforts by a firm or firms to disadvantage competitors by 'either directly denying or persuading or coercing suppliers or customers to deny relationships the competitors need in the competitive struggle.' " *Id.* at 294, quoting L. Sullivan, Law of Antitrust 261-62 (1977).

Northwest Wholesale identified three characteristics as indicative of per se illegal boycotts: (1) the boycott

cuts off access to a supply, facility, or market necessary to enable the victim firm to compete; (2) the boycotting firm possesses a dominant market position; and (3) the practices are not justified by plausible arguments that they enhanced overall efficiency or competition. *Id.* Under these or similar circumstances, the Court held, the danger of anticompetitive injury was sufficiently great that per se treatment was warranted. *Id.*[8]

In the absence of such a showing, however, the Court has since admonished that the category of activities comprising group boycotts "is not to be expanded indiscriminately." *FTC v. Indiana Federation of Dentists*, 476 U.S. 447, 458 (1986). Of particular relevance to this case, the Court added: "Moreover, we have been slow to condemn rules adopted by professional associations as unreasonable *per se* . . . and, in general, to extend *per se* analysis to restraints imposed in the context of business relationships where the economic impact of certain practices is not immediately obvious." *Id.* at 458-59.

However, the Court has not evidenced a similar reluctance to apply a rule of reason analysis to strike down rules of professional associations. In *Indiana Federation of Dentists,* the dentists formed a federation to continue the Indiana Dental Association's former policy of refusing to submit x-rays to dental health insurers with dental claim forms. Insurers requested the x-rays so that their administrators could determine whether the recommended course of treatment was reasonable. Applying a rule of reason test, the Court ruled that the Federation's practice violated the antitrust laws.

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8 The Court's approach seems to suggest that the facts be developed as in a rule of reason case, or at least almost as fully, in order to determine whether the conduct is per se illegal.

Barry is instructive on the approach in this circuit to group boycott claims against professional organizations. The court applied rule of reason analysis to determine the effect on competition of Blue Cross's agreement with physicians. The *Barry* plaintiffs argued that the Blue Cross plan had the effect of boycotting nonmember physicians by interfering with their access to subscribers. Since nonmember services were reimbursed at a lower rate, the difference to be paid by the individual patient, they contended, few patients would consent to referral to a nonmember; this was tantamount to a refusal to deal. We rejected this argument, reasoning that the diversion of patients from other physicians was little different from

> the ordinary consequence of every commercial contract . . . When a consumer contracts to buy services from one health plan, the consumer will then have little or no demand for the services of a nonparticipating physician, especially if the consumer would have to pay more for those services. The contract does not mean that the parties have agreed to an unlawful concerted refusal to deal.

Barry, 805 F.2d at 872. In upholding the practice, however, we took pains to distinguish *Virginia Academy*, in which there was also an allegation of boycott:

> [i]n that case, Blue Shield reimbursed for psychologists' services only when billed through a member physician. Psychiatrists, who compete with psychologists, did not face this obstacle because, as medical doctors, they could simply become members of Blue Shield. By contrast, in the present case, Blue Cross *does not discriminate* against a

particular class of medical provider, but instead is willing to purchase services from all physicians on equal terms.

Id. at 873 (emphasis added).

Obviously, the fact that OPS *does* discriminate against a class of providers distinguishes this case from *Barry*. While, standing alone, OPS's two-tier fee system could probably withstand a "boycott" challenge under *Barry*, when coupled with OPS's long refusal to admit podiatrists, it is doubtful whether OPS was, in fact, "willing to purchase services from all [practitioners] on equal terms." *Id.*

OPS has the burden under *Barnes* of putting forward a plausible, justifiable explanation for its conduct. It stipulated that it would "not defend this case in any way on the basis that the quality of health care provided by podiatrists is inferior to that provided by other providers of health care." Instead, it claims that "problems with podiatrist claims overutilization"[9] motivated its decision to exclude podiatrists from membership. Brief of Appellee at 9. Even if this is a plausible and legitimate basis for exclusion, we find that appellants sustained their burden under *Barnes* of raising a reasonable inference, grounded in evidence, to refute OPS's claimed justification. Again without deciding any factual issues, we note that the record includes testimony from a former OPS board member, Dr. Price, suggesting that the exclusion of podiatrists was prompted neither by considerations of cost nor by fears of overbilling. Appellants have also pro-

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9 It is unclear whether the contention is that patients sought unnecessary care or that podiatrists performed unnecessary procedures.

duced evidence that the overall costs for foot procedures performed by podiatrists were lower than those of OPS members. *See* Reply Brief of Appellants at 13-14.

Viewing the evidence in the light most favorable to appellants, we must conclude that they are entitled to go to trial on their group boycott theory. Whether ultimately the conduct can be sustained as justified or should be condemned either as a per se violation or under a rule of reason analysis should be determined after a fully developed record at trial. Summary judgment should not have been granted.

CONCLUSION

Appellants asked that we direct the district court to enter summary judgment in their favor. We conclude that genuine issues of material fact remain. In such a case that is rife with factual complexity, summary judgment for either side is rarely justified. *See Barnes*, 759 F.2d at 681. Accordingly, we decline appellants' invitation, reverse the summary judgment in favor of OPS and remand for trial.

REVERSED and REMANDED.

App. C

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CLERK, U.S. DISTRICT COURT
DISTRICT OF OREGON
By _____

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

JOHN HAHN, WADE LIGGETT, JOSEPH AIZAWA, V. G. LIVINGSTON, HUGH FRAZER, and HIDE AIZAWA,	)	
Plaintiffs,	)	Civil No. 78-887 LE
v.	)	ORDER
OREGON PHYSICIANS' SERVICE, an Oregon nonprofit corporation; and PHYSICIANS' ASSOCIATION OF CLACKAMAS COUNTY, an Oregon corporation,	)	
Defendants.	)	

Plaintiffs John Hahn, Wade Liggett, Joseph Aizawa, V.G. Livingston, Hugh Fraser, and Hide Aizawa, all podiatric physicians, brought this action against the Oregon Physicians' Service alleging a combination or

conspiracy in restraint of trade and monopoly, attempted monopoly, and a combination or conspiracy with other persons to monopolize, all in violation of the Sherman Antitrust Act, 15 U.S.C. §§ 1 and 2. The podiatrists move this court for summary judgment on the issue of liability and alternatively, for partial summary judgment pursuant to Fed. R. Civ. P. 56 (a). They also move the court for leave to file a third amended complaint to add plaintiffs' professional service corporations as plaintiffs and Blue Cross/Blue Shield of Oregon as a defendant. The Oregon Physician's Service (OPS) also moves for summary judgment in its favor on the issue of liability.

FACTS

Plaintiffs are doctors of podiatric medicine (D.P.M.s) licensed to practice podiatry in Oregon under O.R.S. Chapter 682. O.R.S. 682.101(3) provides that " 'Podiatry' means the diagnosis or the medical, physical or surgical treatment of ailments of the human foot . . ." Podiatrists may perform all foot procedures that medical doctors (M.D.s) and doctors of osteopathic medicine (D.O.s) perform, with the exceptions of administering general or spinal anesthetics and amputating the foot.

In the early 1970's several plaintiffs applied for membership in OPS. OPS was a prepaid health care plan which directly reimbursed its member physicians for their services to subscribers to the plan. Representatives of OPS advised plaintiffs who applied that podiatrists were not eligible because OPS membership was limited to doctors of medicine and osteopathy.[1]

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[1] The amended Articles of Incorporation state OPS membership is limited to "physicians and surgeons licensed to practice medicine and surgery in the State of Oregon by the

In 1981, OPS had 286,218 subscribers. Blue Cross/Blue Shield of Oregon (BCBSO) merged with OPS in 1983, and as the survivor corporation, expressly assumed all OPS's rights, obligations and liabilities. BCBSO continued OPS' practice of not admitting podiatrists as members of its plan. In 1985, BCBSO had over 800,000 subscribers.

In 1978, a group of podiatrists created the Fair Action Committee for Education, Inc., (FACE) as a nonprofit corporation to which certain podiatrists assigned any legal rights they had under the Sherman Act. Five of the six named plaintiffs here assigned their claims to FACE.

FACE brought four separate actions against twelve prepaid health care plans, including OPS, for violations of the Sherman Antitrust Act. After numerous court actions and settlement negotiations, OPS is the only defendant remaining.[2] On June 27, 1986 the Honorable Gus J. Solomon bifurcated the issues of damages and liability for trial.

In 1980 FACE dissolved. Before its dissolution, the complaint was amended to substitute the named individual podiatrists for FACE in view of OPS' contention that FACE was not the real party in interest and therefore, had no standing.

(Footnote 1 continued)

Oregon State Board of Medical Examiners . . ." The trustees of OPS adopted this amendment to their Articles of Incorporation and executed it on March 7, 1953.

2 Plaintiffs request to file a third amended complaint which adds BCBSO as a defendant.

As non-members of OPS and its successor BCBSO,[3] podiatrists who render services to OPS subscribers are reimbursed different from OPS members. OPS directly reimburses its member physicians at up to the 90th percentile of full reimbursement of other physicians of similar specialty. In contrast, when a non-member physician renders service to an OPS subscriber, OPS issues payment to the subscriber at the 60th percentile of full reimbursement. The non-member physician must collect that amount from the subscriber, and may bill for the balance of the value of his or her services. OPS members may not bill for the balance of their services by agreement with OPS/BCBSO.

The podiatrists claim the effect of this difference in reimbursement amount and method "is that in each case [the podiatrist] will receive less money than if the full allowance available to members was paid." Plaintiffs' memorandum in support of the motion for summary judgment, p. 16. They claim they have lost and will continue to lose clients who subscribe to OPS because OPS will not pay in full for services rendered to those clients.

The plaintiffs claim they are forced to compete unfairly with OPS member physicians for clients who need foot care in the Portland metropolitan area because OPS/BCBSO refused to admit them as members or to reimburse them in the same fashion as members. The podiatrists allege OPS is "dominated and controlled" by their direct competitors, M.D.s and osteopaths. By virtue

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3 In August 1985, BCBSO allowed podiatrists to become members for the first time. The second amended complaint and this opinion describe conditions before podiatrists were admitted as BCBSO members.

of this domination and control, plaintiffs claim the M.D.s and osteopaths in OPS have conspired to boycott podiatrists, to fix prices, and to monopolize foot care services in the Portland metropolitan area, all in violation of the Sherman Antitrust Act, 15 U.S.C. §§ 1 and 2.

LEGAL STANDARDS

Summary judgment is appropriate when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c).

All reasonable doubts as to the existence of genuine issues of material fact should be resolved against the moving party. Hector v. Wiens, 533 F.2d 429, 432 (9th Cir. 1976). A material issue of fact is one that affects the outcome of the litigation and requires a trial to resolve the parties' differing versions of the truth. United States v. First National Bank, 652 f.2d [sic] 882, 887 (9th Cir. 1981).

DISCUSSION

Plaintiffs contend a horizontal agreement[4] existed among their direct competitors, the physican members of OPS's Board of Trustees, to restrain trade and monopolize foot care services in the Portland area. Evidence plaintiffs present of the alleged conspiracy includes the domination of the OPS Board of Trustees by a physician majority; selection of physician Board mem-

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4 Plaintiffs claim OPS is merely an agent of the member physicians who dominate and control it. Therefore, they claim a horizontal rather than a vertical agreement accurately describes the type of conspiracy they allege.

bers by local medical societies and the Oregon Medical Association; a Medical Advisory Committee of the Board of Trustees with jurisdiction over issues of membership application which was either exclusively or mostly M.D.s; and members' acknowledgment and agreement to be bound by the OSP [sic] Articles of Incorporation and Bylaws, including those provisions relating to the exclusion of non-M.D.s and D.O.s.

Plaintiffs state that under the domination and control of its physician members, the OPS Board in 1982 specifically rejected podiatrists as members and in 1972 decided to reimburse podiatrists at the same lower level as non-member physicians.

15 U.S.C. § 1 Claim

Section 1 of the Sherman Act, 15 U.S.C. § 1, prohibits "every contract, combination * * * or conspiracy, in restraint of trade or commerce * * *." To establish a violation of Section 1, plaintiffs must prove defendants engaged in concerted action. Therefore, in a motion for summary judgment directed against them, plaintiffs must allege sufficient facts to raise a reasonable inference of an illegal combination or conspiracy to overcome the motion. Filco v. Amana Refrigeration, Inc., 709 F.2d 1257, 1261 (9th Cir. 1983).

I find plaintiffs do not present sufficient facts to raise a reasonable inference of an illegal combination or conspiracy on the part of the OPS Board or its member physicians to restrain trade in the provision of foot care services in the Portland metropolitan area. The record before me demonstrates the majority of the OPS Board of Trustees in the relevant time periods is not competing economically with plaintiff podiatrists for the provision of foot care in this market area. Plaintiff John

Hahn practices podiatry in Tigard, Oregon. Plaintiff Joseph Aizawa practices podiatry in Milwaukie, Oregon. Plaintiffs Wade Liggett, Hide Aizawa, and V.G. Livingston practice podiatry in Portland, Oregon. V.G. Livingston also practices in Vancouver, Washington.

In contrast, the majority of the physicians on a typical OPS Board of Trustees does not practice in the Portland metropolitan area and does not specialize in foot care.[5]

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[5] A list of the 1976 OPS Board of Trustees shows the location and type of practice of each trustee:

1976

William C. Scott, M.D., Chairman, Portland, Internal Medicine
Thomas E. Matheson, M.D., Vice Chairman, Prineville, Family Practice
John R. Higgins, M.D., Secretary, Baker, Family Practice
Henry D. Barker, M.D., Newport, Family Practice
Berton D. Braly, M.D., Corvallis, Anesthesiologist
Dean Bryson, Salem, Associate Justice Supreme Court of Oregon
J. Don Chapman, Portland, Regional Administrator, Small Business Administration
William W. Cook, Portland, Vice President, U. S. National Bank
Robert R. Cooper, M.D., Salem, Family Practice
Delbert R. Ellis, Portland, President Amfac Mortgage Co.
Robert H. Elsner, Portland, Association Executive
John T. Flaxel, M.D., Bend, Ophthalmology
Robert C. Kennedy, Portland, President, Oregon AFL-CIO
Albert M. Lewis, M.D., Forest Grove, Surgery
C. Gary Loosli, M.D., St. Helens, Family Practice
Anthony Meeker, Amity, Agri-business
Martin D. Merriss, M.D., The Dalles, Surgeon
Robert R. Mooers, M.D., Roseburg, Family Practice
Thomas L. Morris, Portland, Investment Advisor
Max H. Parrott, M.D., Portland, OB-GYN
Timothy A. Patrick, M.D., Astoria, Surgery

Some Board members are not physicians, and OPS presents evidence uncontroverted by plaintiffs that some of the physicians were retired during their terms as trustees. In addition, a 1978 amendment to the OPS Bylaws required fifty percent non-physician members of the OPS Board. Even if it assumed the trustees determined the membership and reimbursement issues for OSP [sic], they would have no economic interest in restraining trade in the provision of foot care service in Portland. Pa. Dental Ass'n v. Medical Service Ass'n of Pa., 745 F.2d 248, 258 (3rd Cir. 1984), cert. denied, 105 S. Ct. 2021 (1985) (no horizontal conspiracy exists when only 1/16th of the decision-makers are competitors in the relevant market).

Plaintiffs present no evidence that any OPS member physicians who were their direct competitors for foot care in the Portland metropolitan area conspired with any OSP [sic] Board of Trustees. Under these circumstances, no facts raise a reasonable inference of any illegal combination or conspiracy to overcome OPS' motion for summary judgment on a violation of 15 U.S.C. § 1.

On the contrary, plaintiffs present evidence that OPS subscribers go to both OPS physicians and to non-member podiatrists despite the fact these subscribers

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(Footnote 5 continued)

William D. Proppe, Ph.D., Portland, Superintendent, Washington County Education Service District
William E. Purnell, M.D., Salem, Family Practice
Weldon T. Ross, M.D., McMinnville, Family Practice
Estes Snedecor, Jr., Portland, Vice Pres., Portland General Electric
Marvin J. Urman, M.D., Portland, Family Practice
Julius Varga, M.D., Albany, County Health Officer
W. Rich Warrington, M.D., Portland, Surgeon

are not fully reimbursed for podiatric treatment. Plaintiffs present an exhibit prepared from computer reports showing that in 41 instances in 1979-1980 an OPS subscriber chose to visit both a podiatrist and an OPS M.D. for foot care. This information demonstrates OPS subscribers with foot problems exercise free choice in selecting a podiatrist or physician for treatment. Further, the podiatrists were highly successful in collecting balances due from the subscribers for the full value of the treatment provided. These facts show competition to provide foot care services in Portland is healthy and needs no protection from antitrust law. Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc., 429 U.S. 477, 488 (1977).

The Ninth Circuit has recently held that health care plans like the OPS/BCBSO plan described here do not violate antitrust laws. Barry v. Blue Cross of California, slip opinion No. 85-6448, Dec. 4, 1986.

Based on the facts of this case, which fail to show any evidence of a horizontal agreement to restrain trade among OPS physicians, and Barry v. Blue Cross, I find no violation of Section 1 of the Sherman Antitrust Act.

15 U.S.C. § 2 Claim

The podiatrists also claim OPS has monopolized or attempted to monopolize the foot care services market in the Portland metropolitan area in violation of Section 2 of the Sherman Antitrust Act. To prevail on the monopoly claim they must establish OPS had a sufficiently large share of a relevant market. Barry v. Blue Cross of California, slip opinion No. 85-6448, Dec. 4, 1986 at 17. The OPS prepaid health care plan covered only 15 or 16% of the individuals in the Portland Metropolitan area at any one time. Such a market share

is far below what is required for a monopoly. See Forro Precision, Inc. v. International Business Machines Corp., 673 F.2d 1045, 1058 (9th Cir. 1982) (a thirty-five percent market share did not permit an inference of monopoly power), cert. denied, 105 S. Ct. 2664 (1985).

Proof of an attempt to monopolize requires three elements: (1) specific intent to control prices or destroy competition with respect to a part of commerce, (2) predatory or anticompetitive conduct directed to accomplishing the unlawful purpose, and (3) a dangerous probability of success. Purex Corp. v. Proctor & Gamble Co., 596 F.2d 881, 890 (9th Cir. 1978). Plaintiffs prove none of these elements given the facts that the OPS Board of Trustees does not compete with the plaintiff podiatrists, and OPS has such a small share of the market.

No genuine issues of fact exist with respect to plaintiffs' claims under 15 U.S.C. §§ 1 and 2.

The issue of standing need not be discussed given the disposition of this case.

IT IS ORDERED that defendant OPS' motion for summary judgment on the issue of liability is GRANTED. Plaintiffs John Hahn, Wade Liggett, Joseph Aizawa, V.G. Livingston, Hugh Fraser and Hide Aizawas' motion for summary judgment and for partial summary judgment is DENIED. IT IS FURTHER ORDERED that plaintiffs' motion to file a third amended complaint to add plaintiffs' professional corporations as plaintiffs and BCBSO as a defendant is denied.

Dated this 10th day of February, 1987.

/s/ EDWARD LEAVY
United States District Judge

App. D

U.S. DISTRICT COURT
DISTRICT OF OREGON
F I L E D
MAR 10, 1989
ROBERT M. CHRIST, CLERK
BY DEPUTY

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

JOHN HAHN, WADE LIGGETT, et al,	)	
	)	
Plaintiffs-Appellants,	)	
	)	
vs.	)	
	)	
OREGON PHYSICIANS' SERVICE, et al	)	No. 87-3875
	)	
Defendants-Appellees.	)	CV 78-0887-LE

APPEAL from the United States District Court for the _____ District of _____

THIS CAUSE came on to be heard on the Transcript of the Record from the United States District Court for the Portland District of Oregon and was duly submitted.

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court, that the _____ judgment of the said District Court in this Cause be, and hereby is REVERSED AND REMANDED.

Filed and entered 11/4/88 (Amended 2/27/89)

App. E

FILED

MAR 31 1989

CATHY A. CATTERSON, CLERK
U.S. COURT OF APPEALS

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

JOHN HAHN; WADE LIGGETT; JOSEPH AIZAWA; V.G. LIVINGSTON; HUGH FRASER; HIDE AIZAWA,	)	
Plaintiffs-Appellants,	)	No. 87-3875
v.	)	CV 78-0887-LE
OREGON PHYSICIANS' SERVICE; PHYSICIANS' ASSOCIATION OF CLACKAMAS COUNTY,	)	ORDER
Defendants-Appellees.	)	

BEFORE: HUG, FLETCHER, and NELSON, Circuit Judges.

Appellee's petition for rehearing of amended opinion is denied.

App. F

[¶ 66,849] Irving Ear, Nose, Throat & Allergy Clinic, et al v. Group Hospital Service, Inc., et al.

U. S. Court of Appeals, Fifth Circuit, No. 84-1404. Dated October 31, 1985. Appeal from U. S. District Court, Northern District of Texas.

Before RANDALL, HILL and DAVIS, Circuit Judges.

[OPINION]

DAVIS, Cir. J.: Appellants, Herbert R. Kasnetz, M.D., an ear, nose, throat and allergy specialist, and his clinic Irving Ear, Nose, Throat & Allergy Clinic, brought this action against three Texas corporations doing business as Blue Cross/Blue Shield of Texas, alleging violations of Section 1 of the Sherman Act, 15 U.S.C. § 1. The district court directed a verdict in favor of the defendants. For the reasons set forth below, we affirm.

I.

The pertinent facts are undisputed. The three defendants to this action, Group Hospital Service, Inc. (GHS), Group Life & Health Insurance Company (GL&H), and Group Medical & Surgical Service (GM & SS), are licensed to operate under the service mark Blue Cross/Blue Shield of Texas. GHS was chartered in 1939 under Article 20 of the Texas Insurance Code as a non-profit hospital service company. GHS writes individual and group hospital plans. GL&H is a wholly-owned subsidiary of GHS, which was acquired by GHS in 1976. Since 1976, GL&H has underwritten group medical and surgical policies to complement the hospitalization

policies written by GHS. GHS formed the third defendant, GM & SS, as a statewide mutual assessment, nonprofit corporation under Article 14 of the Texas Insurance Code. This entity is owned by its policy holders. Before 1976, when GHS acquired GL&H, GM & SS marketed individual medical and surgical policies; after GHS acquired GL&H, GM & SS stopped writing new business and limited its activity to servicing existing contracts.

The officers of the three defendants operating under the Blue Cross/Blue Shield umbrella are identical. All sales and claims employees are carried on the payroll of GHS and they perform functions, as required, for all three companies. The twenty directors of GHS also serve on the boards of GL&H and GM & SS. The latter two entities have three additional directors. Common board meetings are held for all three entities.

Blue Cross/Blue Shield of Texas instituted a cost containment program in 1976 in which it undertook to reimburse physicians fees on the basis of what is considered usual, customary, and reasonable (UCR) fees. Defendants established UCR fees for a number of individual medical procedures by reviewing actual fees charged by a large number of physicians practicing in a geographic area. It also evaluated physicians' patterns of practice to assess how often specific procedures were performed for a given number of patients. With this information, the insurer identified physicians who sought to charge fees it considered excessive or who performed medical services of questionable necessity. The insurer suggested that those physicians so identified reduce their charges and services to the acceptable range. If the physician did not agree to do so, the insurer declined to pay the physician and exercised the right granted to it in its policy to directly reimburse patients for services

provided by these physicians based on the UCR charge.[1] In addition, claims for those physicians' services were subjected to closer prepayment scrutiny than that customarily given.

Kasnetz operated his ear, nose, throat and allergy clinic in Irving, Texas. Approximately one-third of his patients were insured by Blue Cross/Blue Shield. Until 1976, Kasnetz billed Blue Cross/Blue Shield directly for payment of patient services and the insurer routinely reimbursed the physician. In 1976, however, the insurer identified Kasnetz as a physician who performed medically unnecessary procedures and who assessed multiple charges for essentially the same services. The insurer informed Kasnetz that payment for covered services for its policy holder would be made to the policy holders and not to Kasnetz, and then only after prepayment review.

Kasnetz brought this action complaining that the insurer's cost containment program, which led to a reduction in his income and the size of his practice, violated Section 1 of the Sherman Act. He alleged: (1) horizontal and vertical price fixing; (2) horizontal group boycott; and (3) restraint of trade. At the close of the plaintiff's case after five days of jury trial, the district court directed a verdict in favor of the defendant insurer. The district court concluded that the evidence was insufficient to establish a conspiracy because the three defendants were a single economic entity incapable of conspiracy; alternatively, the district court assumed the defendants had the capacity to conspire and nevertheless found evidence of a Sherman Act violation insufficent to raise a jury issue.

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1 Blue Cross/Blue Shield's standard policy provided for payment of a specific percentage of the reasonable charges for medically necessary services.

II.

A.

We review this appeal from a directed verdict under the familiar *Boeing* standard and consider:

> [A]ll of the evidence--not just that evidence which supports the non-mover's case--but in the light and with all reasonable inferences most favorable to the party opposed to the motion. If the facts and inferences point so strongly and overwhelmingly in favor of one party that the Court believes that reasonable men could not arrive at a contrary verdict, granting of the motions is proper.

Boeing Co. v. Shipman, 411 F. 2d 365, 374 (5th Cir. 1969) (en banc).

To prevail under Section 1 of the Sherman Act, plaintiff must show a contract, combination or conspiracy, in restraint of trade or commerce. 15 U.S.C. § 1.

The district court based its decision that the defendant corporations lacked the capacity to conspire on the notion that the three defendants acted as a single entity. The defendants contend that *Copperweld Corp. v. Independence Tube Corp.* [1984-2 TRADE CASES ¶ 66,065], ___U. S.___, 104 S. Ct. 2731, 81 L. Ed. 2d 628 (1984), supports the district court's ruling and is controlling. In *Copperweld*, the Court held that a parent corporation and its wholly-owned subsidiary have a "unity of purpose or a common design" and are incapable of conspiring with each other. See also *Century Oil Tool, Inc. v. Production Specialties, Inc.* [1984-2 TRADE CASES ¶ 66,136], 737 F. 2d 1316 (5th Cir. 1984). Under the teaching of *Copper-*

weld, the district court was clearly correct in concluding that GHS and its wholly-owned subsidiary, GL&H, are incapable of conspiring with each other. Because the alternate ground for the district court's ruling is solidly grounded in established law, we find it unnecessary to decide whether *Copperweld* should be extended to hold that GM & SS is incapable of conspiring with the other two defendants.

B.

In his complaint and in his brief on appeal, Kasnetz alleged per se violations of Section 1 by defendants in agreeing to fix prices and to conduct a horizontal boycott.[2] In addition, he alleged a conspiracy in restraint of trade, a Section 1 claim to be tested under the rule of reason. At oral argument, Kasnetz conceded that he had failed to establish a per se violation of Section 1 but argued that under the rule of reason, he had presented sufficient evidence to have his case submitted to the jury. We agree with the conclusion of the district court that insufficient evidence was adduced to present a jury issue

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2 Actions identified by courts as per se violations include price fixing agreements and horizonal group boycotts and are presumed to have a pernicious effect on competition. Once per se illegal activity is shown, no evidence need be presented of anti-competitive effects. *Northern Pacific Ry. Co. v. United States* [1958 TRADE CASES ¶ 68,961], 356 U. S. 1, 5, 78 S. Ct. 514, 2 L. Ed. 2d 545 (1958).

on plaintiff's restraint of trade claim under a rule of reason analysis as well as his claim of a per se violation.[3]

To survive a motion for directed verdict on the restraint of trade claims, analyzed under a rule of reason, Kasnetz was required to adduce evidence tending to show that the alleged agreement has an effect on competition among physicians in his geographic area; he was required to present evidence of "antitrust injury, . . . injury of the type the antitrust laws were intended to prevent and flows from that which makes defendants' acts unlawful; the injury must reflect the anticompetitive effect either of the violation or of anticompetitive acts made possible by the violation." *Brunswick Corp. v. Pueblo Bowl-O-Mat*, [1977-1 TRADE CASES ¶ 61,255], 429 U. S. 477, 489, 97 S. Ct. 690, 50 L. Ed. 2d 701 (1777) [sic].

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3 The district court's decision to direct a verdict on the alleged per se violations is clearly correct on the undisputed facts presented in this case. The three defendants did not compete with each other, or hold themselves out as competitors: Also, Kasnetz provided medical services and did not sell health insurance so Kasnetz did not compete with the three defendants. Thus, no evidence of horizonal price fixing or illegal boycott by defendants was adduced. See *Plueckhahn v. Farmers Ins. Exchange* [1985-1 TRADE CASES ¶ 66,338], 749 F. 2d 241, 245 (5th Cir. 1985); *Blackburn v. Crum & Forster* [1980-1 TRADE CASES ¶ 63,164], 611 F. 2d 102, 104 (5th Cir.), cert. denied, 447 U. S. 906 (1980). Likewise, because Kasnetz sold no products, goods or services supplied him by the defendants, no evidence of a vertical link necessary to establish vertical price fixing (as in resale price maintenance) was presented. See *Royal Drug Co. v. Group Life & Health Ins. Co.* [1984-2 TRADE CASES ¶ 66,137], 737 F. 2d 1433, 1438 (5th Cir. 1984), cert. denied, 105 S. Ct. 912 (1985).

Kasnetz presented evidence in support of his contentions that the insurer's cost containment program injured his practice and reduced his income but he did not demonstrate injury to competition in the market area. He showed that the insurer's effort to reduce medical costs had the effect of reducing the number of patients who came to him for care; those who had difficulty with reimbursement stopped using his services and no longer referred friends to him. Kasnetz did not show, however, that Blue Cross/Blue Shield's program affected competition among physicians of his specialty or among any physicians in his geographic area. Thus, Kasnetz utterly failed to present proof from which a reasonable person could infer an unreasonable restraint of trade.

Affirmed.

Supreme Court, U.S.
FILED
AUG 2 1989
JOSEPH F. SPANIOL, JR.
CLERK

No. 89-13

IN THE

Supreme Court of the United States

October Term, 1988

OREGON PHYSICIANS' SERVICE,
an Oregon nonprofit corporation,

Petitioner,

v.

JOHN HAHN, WADE LIGGETT, JOSEPH AIZAWA,
V. G. LIVINGSTON, HUGH FRASER and HIDE AIZAWA,

Respondents.

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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QUESTIONS PRESENTED

I. In permitting plaintiff Doctors to proceed to trial on their price-fixing claim under 15 U.S.C. §1, did the Ninth Circuit correctly view this case as "akin to *Maricopa*," when the summary judgment record showed (1) that physicians formed a majority of the Oregon Physicians' Service ("OPS") board of trustees; (2) that OPS member physicians in a wide variety of medical specialties were direct and potential competitors of podiatrists for foot care; (3) that OPS member physicians agreed to the maximum fees they would charge for foot care procedures; (4) that OPS member physicians agreed to reimburse nonmember podiatrists at a lower rate for the same procedures; and (5) that OPS membership and reimbursement policies resulted in shifts in consumer demand for foot care from podiatrists to OPS member physicians?

II. In permitting plaintiff Doctors to proceed to trial on their group boycott claim under 15 U.S.C. §1, did the Ninth Circuit correctly apply the *Matsushita* summary judgment standard to conclude that plaintiff Doctors' evidence tended to exclude legitimate pro-competitive justifications for OPS membership policies, since (1) an OPS board member testified that no such pro-competitive justifications had been considered by OPS; and (2) even if alleged "problems with podiatrist claims overutilization" was a "plausible, justifiable explanation" for OPS's refusal to admit podiatrists, it had been rebutted by evidence that podiatrists' overall costs for foot care were lower than those of OPS members?

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IN THE

Supreme Court of the United States

October Term, 1988

OREGON PHYSICIANS' SERVICE,
an Oregon nonprofit corporation,

Petitioner,

v.

JOHN HAHN, WADE LIGGETT, JOSEPH AIZAWA,
V. G. LIVINGSTON, HUGH FRASER and HIDE AIZAWA,

Respondents.

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

STATEMENT OF THE CASE

Procedural History

The Ninth Circuit opinion in *Hahn v. Oregon Physicians' Service*, 868 F.2d 1022 (9th Cir. 1989) ("*Hahn*") summarizes the lengthy procedural history of this litigation. *Id.* at 1025. In light of the characterization by OPS of some of the earlier opinions in this case, OPS Petition at 2-3 and footnote, it is important to clarify that in *Hahn v. Oregon Physicians' Service*, 689 F.2d 840, 842 (9th Cir. 1982), the Ninth Circuit held that "[t]he defendants have introduced no evidence tending to

establish that there are any *bona fide* risk-related reasons for an insurer to distinguish between the services of M.D.'s and podiatrists, much less that such a distinction is at the core of what is commonly understood to be the 'business of insurance.' " *Id.* at 843.

The court also rejected the finding that plaintiffs had failed to meet the interstate commerce jurisdictional requirement and remanded for additional fact-finding. Defendants' petition for writ of certiorari was denied. 462 U.S. 1133 (1983). Thereafter, a trial was held on the impact of defendants' conduct on interstate commerce. After hearing fact and expert witnesses and reviewing extensive computer billing documentation, the district court held that the activities of OPS and the other remaining defendant had a "not insubstantial" effect on interstate commerce. Defendants never sought review of this intensively factual finding and OPS's suggestion that the issue is somehow open to review by this Court five years later is baseless and wholly inappropriate. OPS Petition at 4-5, footnote.

The Ninth Circuit Decision

In reviewing the summary judgment record, the Ninth Circuit was guided by and cited this Court's decisions in *Matsushita Electric Industrial Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574 (1986); *FTC v. Indiana Federation of Dentists*, 476 U.S. 447 (1986); *Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co.*, 472 U.S. 284 (1985); *NCAA v. Board of Regents*, 468 U.S. 85 (1984); *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982); *United States v. Topco Associates, Inc.*, 405 U.S. 596 (1972); and *Radiant Burners, Inc. v. Peoples Gas, Light & Coke Co.*, 364 U.S. 656 (1961).

The Ninth Circuit also examined circuit court opinions that specifically distinguish between (1) unilateral action

by an independent single corporate entity that purchases medical services from physicians and (2) concerted action by a horizontal combination composed of, and controlled by, the physicians who provide competing medical services.

The court found that by statute, plaintiff/respondent podiatrists (hereinafter "plaintiff Doctors") "are licensed to perform all foot procedures that medical doctors (M.D.'s) and doctors of osteopathy (D.O.'s) may perform, except that they may not administer general or spinal anesthetics or perform amputations. O.R.S. § 677.805(4)." *Hahn*, 868 F.2d at 1024. The President of OPS and its successor, Blue Cross/Blue Shield of Oregon ("BCBSO") was unaware of any distinction between foot care services provided by an OPS member physician and those provided by a podiatrist.[1]

Plaintiff Doctors presented evidence that the practice of podiatry includes procedures employed by no less than 22 medical specialties, leading the court to conclude that "many doctors are direct competitors to podiatrists, at least as to some of their services." *Id.* at 1029 and n.7. Based on comparison of this list of specialties with the OPS member physician list, plaintiff Doctors' economics expert witness determined that 73 percent of OPS member physicians in the Portland metropolitan area were in medical specialties performing some treatment of the foot.[2]

Plaintiff Doctors submitted evidence that (1) local county medical societies nominated physician members of OPS to the board of trustees, which nominees were in turn submitted to the Oregon Medical Association for approval and ultimate

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[1] CR 544 at 158. While the Ninth Circuit opinion in *Hahn* references enough of the summary judgment record to uphold its reversal of the trial court's grant of summary judgment, plaintiff Doctors will occasionally reference evidence in the record but not specifically recited by the court by the "Clerk's Record" designation.

[2] CR 597 at 5, 10.

election;[3] (2) a majority of OPS's governing board of trustees were physicians, *id.* at 1024; (3) membership in OPS was limited to M.D.'s and D.O.'s, *id.*; (4) "[f]rom 1974 to 1983, between 90 and 93 percent of all eligible M.D.'s and D.O.'s in Oregon were OPS members," *id.*; (5) based solely upon their licensure, plaintiff Doctors and all other podiatrists were not permitted to become members of OPS, *id.*; and (6) when an M.D. or D.O. became a member of OPS, he or she signed a membership agreement reflecting agreement to be bound by the Bylaws and Articles, including those provisions relating to exclusion of non-M.D.'s and D.O.'s.[4]

Plaintiff Doctors presented evidence that on two occasions, a physician-controlled OPS board of trustees decided to perpetuate the exclusion of podiatrists from membership. The Ninth Circuit referenced one of these occasions: "In 1982 the board contemplated extending membership to additional classes of providers, but decided to offer membership only to optometrists." *Id.*

In 1982, the Ninth Circuit found no evidence of "*bona fide* risk-related reasons" for distinguishing between M.D.'s and podiatrists with respect to foot care. 689 F.2d at 843. In 1989, the Ninth Circuit was equally unimpressed.[5] Without making factual determinations, the court simply noted (1) the stipulation by OPS that it would " 'not defend this case in any way on the basis that quality of health care provided by podiatrists is inferior to that provided by other providers of health care,' " *id.* at 1031; (2) evidence from an OPS board member "suggesting that the exclusion of podiatrists was prompted neither

[3] CR 544 at 160-61; 322-23.

[4] CR 544 at 111; 208-10.

[5] The cobbled-up "plausible, justifiable explanation" advanced by OPS for its conduct was so thoroughly lacking in supporting evidence in the record that the court was "unclear" even as to what it meant. *Hahn*, 868 F.2d at 1031 n.10.

by considerations of cost nor by fears of overbilling"; and (3) evidence "that the overall costs for foot procedures performed by podiatrists were lower than those of OPS members." *Id.* at 1031-32.

The overwhelming majority of policies issued by OPS, despite individual variations, reimbursed nonmember physicians differently from member physicians, "both in price and manner," *id.* at 1029, and the court so noted: "Under a majority of these policies, OPS offers a two-tier system covering health care costs." *Id.* at 1024.

OPS member physicians were paid up to the 90th percentile of fees charged by all OPS member physicians; they agreed to accept such reimbursement as payment in full and not to bill the OPS subscriber for any difference between the reimbursement and the actual fee ("balance bill"). *Id.* at 1025. Nonmembers were reimbursed in an entirely different manner — according to a fixed indemnity schedule. The effect on competition of this indemnity schedule was noted by the Ninth Circuit: "Appellants produced evidence that, on average, OPS members received from OPS 76 cents on the dollar billed while OPS paid podiatrists only 50 cents on the dollar billed." *Id.*

As OPS nonmembers, podiatrists were not precluded from "balance billing." *Id.* However, if they did, the OPS subscriber incurred an out-of-pocket expense that would not have been incurred if the service was obtained from an OPS member physician. Thus, the whole scheme under which OPS member physicians collectively agreed to be reimbursed made "economic sense":[6] such agreements helped OPS member physicians attract patients away from non-members, including nonmember podiatrists. The President of OPS and later BCBSO testified that "purely on a dollar basis, there's the reasonableness that the person is going to go to the place where he gets the least out-of-pocket cost."[7]

[6] *Matsushita*, 475 U.S. at 587.

[7] CR 544 at 174.

It makes equal "economic sense" that podiatrists ran the risk of losing money if they did not balance bill or losing patients and future referrals if they did. Plaintiff Doctors presented evidence of both types of injury, as well as showing significant skewing in consumer demand away from podiatrists' services in the market for foot care, as a result of OPS's conduct.

SUMMARY OF ARGUMENT

The Petition for Writ of Certiorari filed by OPS seeks to portray the Ninth Circuit panel in *Hahn* as judicial renegades riding roughshod over settled antitrust principles, leaving health care plans across the nation no recourse but to circle the wagons and await rescue by this Court.

The court below, however, has charted no new waters, shifted no evidentiary burdens, and exposed health care plans to no new antitrust liabilities. It has merely reversed a summary judgment to permit the plaintiff Doctors to proceed to trial under § 1 of the Sherman Act against a physician-controlled health care plan that (1) excluded all podiatrists from membership; (2) agreed on maximum fees members would be paid for foot care procedures; and (3) agreed to reimburse nonmember podiatrists at a lower rate for the same procedures.

Finding the evidence submitted by plaintiff Doctors "akin" to the facts in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), the court did not find OPS's conduct to be *per se* unreasonable but merely held that plaintiffs could proceed to trial, since "[i]f the OPS plan was, in fact, a horizontal agreement among competitors, it was unlawful *per se*." 868 F.2d at 1030.

Finding it doubtful that OPS had sustained its burden under *Matsushita* of putting forward a "plausible and justifiable explanation" for its refusal to admit podiatrists as members, but that plaintiffs had in any event met their burden of

rebuttal, the court held that plaintiffs were "entitled to go to trial on their group boycott theory." *Id.* at 1032.

REASONS FOR DENYING THE WRIT

The Ninth Circuit decided nothing more than whether a summary judgment of dismissal, not favored in antitrust cases in general, should be upheld. The posture of the case is not conducive to review by this Court. The issues implicated at this preliminary phase have, in any event, recently and comprehensively been addressed by this Court: summary judgment burdens in *Matsushita;* the validity of agreements among competing physicians to establish fees in *Maricopa;* the standards for *per se* versus rule of reason analysis of group boycotts in *Northwest Wholesale Stationers.*

In page after page and at a prodigious rate, OPS piles up citations to cases with which the *Hahn* opinion is said to "conflict." As detailed *infra,* not one of these decisions presents a true conflict justifying review. Each of the decisions relied upon by OPS was addressing unilateral action by single entities, or vertical arrangements, or an absence of any showing of conspiracy, of competition, or of antitrust injury. OPS's conclusory incantation of "conflict" is based only upon courts having reached different results than the Ninth Circuit on different facts than those before the Ninth Circuit. This is a flawed premise and does not satisfy Supreme Court Rule 17.1(a) or (c).

ARGUMENT

I. The Ninth Circuit's Conspiracy Theory Is Entirely Consistent With That Applied to Physician-Controlled Health Care Plans.

The Ninth Circuit cogently stated the "broad proposition" to be synthesized from cases that have addressed antitrust liability of health care plans: "health care plans may

reimburse members and nonmembers differently, both in price and manner, so long as physicians (or the relevant group of competitive providers) do not control the health care plan." *Hahn*, 868 F.2d at 1028-29. Since OPS was indisputably controlled by physicians, who were the relevant group of providers competing with podiatrists, the court permitted plaintiff Doctors' § 1 claim to go forward.

OPS has struggled mightily throughout this litigation to characterize itself as a "single corporate entity" engaged in "unilateral action" rather than a physician-controlled health care plan. The evidence before the Ninth Circuit demonstrated, however, that OPS was not an insurer, an indemnitor, a purchaser of medical services, or a third-party payor — *i.e.*, it did not stand in vertical relation to its member physicians.

Thus, the cases cited by OPS that purportedly are "in conflict" with the Ninth Circuit's ruling are simply not applicable to the facts before the Ninth Circuit: They deal with variations on the question of whether, as a matter of law, a single corporate entity can conspire with itself or whether, as a factual matter and under a higher evidentiary standard, a conspiracy between entities in a *vertical* relation was made out. *E.g., Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 771 (1984) (parent corporation and wholly-owned subsidiary legally incapable of conspiring with each other to violate § 1); *Monsanto Co. v. Spray-Rite Service Corp.*, 465 U.S. 752, 765 (1984) (sufficient evidence for jury to find conspiracy between manufacturer and some of its distributors); *Potters Medical Center v. City Hospital Association*, 800 F.2d 568, 573 (6th Cir. 1986) (defendant hospital's attorney/board member, as well as a staff physician, lacked capacity to conspire with hospital); *Oltz v. St. Peter's Community Hospital*, 861 F.2d 1440, 1450 (9th Cir. 1988) (hospital and "independent contractor" anesthesiologists had sufficiently independent interests so that "collaborated conduct" between them was possible).

The remainder of the circuit court opinions cited by OPS as "in conflict" with the Ninth Circuit's handling of the conspiracy issue in *Hahn* are noteworthy only for the *absence* of evidence or even allegations of an agreement among or concerted action by physicians.

In *Kartell v. Blue Shield of Massachusetts, Inc.*, 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985), the court specifically distinguished the facts before it from a case in which such physician control *was* shown. *Id.* at 925, *citing Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981). Because in the case before it "Blue Shield and the doctors 'sit on opposite sides of the bargaining table,' " the *Kartell* court found *Maricopa* and *NCAA v. Board of Regents*, both "horizontal agreement" cases, "simply not on point." *Id.* at 925, 930.

Similarly distinguishable are *Cooper v. Forsyth County Hospital Authority*, 789 F.2d 278, 281 n. 12 (4th Cir. 1986), in which plaintiffs did not even allege a conspiracy among the members of the hospital's medical-dental staff, and *McKenzie v. Mercy Hospital*, 854 F.2d 365, 367-68 (10th Cir. 1988), in which plaintiff made no allegation that the defendant hospital had allied itself with any other individual to unlawfully tie a patient's choice of physician.

OPS purports to address in Section I of its Petition the issue of whether its structure immunized it from a finding of conspiracy; however, within that section, at page 10, OPS interjects a quite different argument, *i.e.*, that the decisions relied upon by the Ninth Circuit require plaintiff Doctors to show that "actual competitors" in the same specialty as podiatrists controlled the membership and reimbursement policies of OPS. While plaintiff Doctors have structured this Brief in Opposition to mirror the sections of OPS's Petition, for the convenience of the Court, the issue of control by actual competitors is more logically addressed under Section IA, *infra*.

A. *The Ninth Circuit Applied the Classical Formulation of Competitor Control: OPS Was Controlled By Physicians Who Had Previously Pursued Their Own Interests Separately But Then Combined to Act as One for Their Common Benefit.*

The Ninth Circuit rejected the district court's conclusion that as a matter of law, a majority of the OPS board of trustees " 'would have no economic interest in restraining trade in the provision of foot care services in Portland' " because a majority of the physicians on a typical OPS board did not practice in the Portland metropolitan area and did not specialize in foot care. 868 F.2d at 1029. If the Ninth Circuit had *upheld* a requirement that plaintiff Doctors show complete identity of geographic area of practice and medical specialty between themselves and a majority of the board of a physician-controlled health care plan, *then* the Ninth Circuit holding would have been in conflict with decisions by this Court. *E.g., Radiant Burners, Inc. v. Peoples Gas, Light & Coke Co.*, 364 U.S. 656, 657 n.1, 659-60 (1961); *Associated Press v. United States*, 326 U.S. 1, 26-27 (1945) (Frankfurter, J., concurring).

Such a decision would have imposed an unprecedented burden on antitrust plaintiffs and would in essence have rewarded an unlawful combination that reaches so many geographic markets and embraces such an array of competitors that it can always point to such scope and diversity to defeat the antitrust claims of a given competitor in a given location.

Rather, citing *Maricopa* and *Radiant Burners*, the Ninth Circuit articulated the "proper inquiry" with respect to competition:

> The proper inquiry is not whether individual board members themselves were in actual competition with the complaining nonmembers. Rather, the proper inquiry is whether practitioners sharing substantially similar economic interests collectively exercised control of a plan under

> whose auspices they have reached agreements which work to the detriment of competitors.

Hahn, 868 F.2d at 1029 and n.8.

That inquiry was unquestionably satisfied, for purposes of withstanding the summary judgment motion, by the evidence in the record. Based on scope of licensure alone, podiatrists and OPS member M.D.'s and D.O.'s are potential competitors. *Compare* ORS § 677.805(4) *with* ORS § 677.085(4). The court noted that from 1975 to 1981, "physicians were responsible for 90% of foot care billings to OPS." *Hahn*, 868 F.2d at 1030. And podiatrists were a particularly threatening class of potential competitors to M.D.'s and D.O.'s who provided foot care, since, unlike other non-M.D./D.O. health care providers with limited licenses, podiatrists may prescribe drugs and perform surgery.

The high level of *actual* competition for provision of foot care was documented by plaintiff Doctors: under OPS's discriminatory reimbursement policies, 10% of OPS's billings for foot care in the Portland metropolitan area were from podiatrists; during the same period, in the same market, but under the *nondiscriminatory* reimbursement policies of a different health care plan, Blue Cross of Oregon, *30%* of billings for foot care were from podiatrists. The Ninth Circuit concluded from the evidence that "many doctors [M.D.'s and D.O.'s] are direct competitors to podiatrists, at least as to some of their services." *Hahn*, 868 F.2d at 1029 and n.7.[8]

OPS's understanding of the nature of the competition that must be shown to make out a *prima facie* case of horizontal

[8] Plaintiff Doctors' solid showing of direct competition distinguishes this case from *Feldman v. Jackson Memorial Hospital*, 571 F. Supp. 1000 (S.D. Fla. 1983), *aff'd*, 752 F.2d 647 (11th Cir.), *cert. denied*, 472 U.S. 1029 (1985), cited by OPS at page 9, in which the plaintiff podiatrist failed to establish that a group of orthopedic surgeons were his competitors "in any meaningful sense." *Id.* at 1007.

conspiracy is flawed, as was the district court's in this case. At page 10 of its Petition, OPS incorrectly states that "the decisions," including *Pennsylvania Dental*, "narrowly hold that if *actual* competitors (not just generic 'physician') *directly* control the pricing and reimbursement (not just general management of the plan), plaintiffs may state a claim." This is an attempt to resurrect the requirement invented by the district court that to withstand a summary judgment dismissing their § 1 claim, plaintiff Doctors had to show OPS to be controlled by M.D. specialists in foot care practicing in Portland. No case cited by OPS or by the district court supports the imposition of such a requirement.

OPS misreads *Pennsylvania Dental*, in which the Third Circuit rejected plaintiff dentists' horizontal conspiracy claim because "only two members of [Blue Shield's] 32-member board are dentists," so only one-sixteenth of those making the alleged anticompetitive decisions were " 'themselves competitors in the relevant market.' " 745 F.2d at 258. "Generic physicians" did not, and could not, compete with dentists for provision of tooth care, and so the plan was not controlled by even *potential* competitors of plaintiffs.

Certainly, "specialist control" was not required by the court in *Virginia Academy;* it did not require dominance of the Blue Shield board by *psychiatrists*, the actual "specialist" competitors of plaintiff psychologists. *Physician* control of the board was sufficient to make the health care plan a horizontal combination.[9]

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[9] OPS's further argument, that the Ninth Circuit incorrectly relied upon *Virginia Academy* and that *Virginia Academy* "should be limited to its peculiar facts or overruled," OPS Petition at 10, is unsupported and unsupportable. As the Ninth Circuit noted, although *Virginia Academy* predated this Court's opinion in *Maricopa* by two years, the Fourth Circuit "followed substantially similar reasoning." 868 F.2d at 1028 n.4. Further, this Court discussed the reasoning of *Virginia Academy* without any indication of disapproval in *Blue Shield of Virginia v. McCready*, 457 U.S. 465, 469 n.4 (1982).

This Court has recognized that a showing of control of an entity by *potential* competitors of the plaintiffs is sufficient to make out a § 1 claim, and the Ninth Circuit so noted by citing *Radiant Burners, Inc. v. Peoples Gas, Light & Coke* Co., 364 U.S. 656, 657 n.1, 659-60 (1961), with an explanatory parenthetical: "(though only six among 'numerous' members of gas association directly competed with plaintiff, Sherman 1 claim was stated even in absence of proof that six direct competitors controlled association, because association as a whole shared substantially similar economic interests)." *Hahn*, 868 F.2d at 1029 n.8.

The reasons why concerted action by potential competitors supports § 1 liability were articulated by this Court more than 40 years ago, when over 1200 competitors for news nationwide joined together in an association that had the power to exclude applicants for membership from access to news sources:

> Although, as we have said, only a few members will have any direct personal interest in keeping out an applicant, the rest will not feel free to judge him regardless of the effect of his admission on his competitors. Each will know that the time may come when he will himself be faced with the application of a competitor; and that will be true even as to those in whose 'field' no applicant has yet appeared. Unless he supports those who now object to the admission of their competitor, he will not in the future be likely to get their support against his own.

Associated Press v. United States, 326 U.S. 1, 26-27 (1945) (Frankfurter, J. concurring).[10]

[10] OPS's additional argument that any conspiracy in this case must be vertical and not horizontal, OPS Petition at 11, because OPS was sued rather than individual physicians, must be rejected. Denomination of an association or society rather than individuals as defendant is not dispositive of conspiracy analysis. *See Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982); *American Society of Mechanical Engineers, Inc. v. Hydrolevel Corp.*, 456 U.S.

(footnote continued on next page)

The Ninth Circuit's framing of the inquiry regarding competition, 868 F.2d at 1031, is entirely consistent with the *Associated Press* rationale, and in "conflict" with none of the cases cited by OPS.

In *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), this Court addressed only the applicability of the McCarran-Ferguson Act exemption for the "business of insurance," 15 U.S.C. § 1012(b), to a Blue Shield prepaid prescription drug program; it is not clear why OPS cites this decision as relevant to the distinction between horizontal and vertical conspiracies. In *Royal Drug Co. v. Group Life & Health Insurance Co.*, 737 F.2d 1433 (5th Cir. 1984), the Fifth Circuit analyzed the same plan, holding that the pharmacy agreements at issue "do not run between competitors in the pharmaceutical industry, nor between competitors in the insurance industry, but between individual pharmacies and Blue Shield, which does not compete with pharmacies." *Id.* at 1436-37. Finally, there was no allegation of physician control of the defendant insurance plans in *Irving Ear, Nose, Throat & Allergy Clinic v. Group Hospital Service, Inc.*, 1985-CCH Trade Cases ¶ 66,849, 776 F.2d 1046 (5th Cir. 1985), *cert. denied*, 475 U.S. 1090 (1986). The court simply held that under *Copperweld*, the hospital service company and its wholly-owned subsidiary were incapable of conspiring and the plaintiff physician therefore incapable of making out a § 1 claim.

The Ninth Circuit is in conflict with none of these Fifth Circuit opinions. Instead, the OPS plan suffered from the same "Achilles heel" identified in *Royal Drug*: competing health care providers participated in setting fees for themselves and for excluded classes of competitors. 737 F.2d at 1436 n.1.

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556 (1982); *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978); *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975); *Radiant Burners, Inc. v. Peoples Gas, Light & Coke Co.*, 364 U.S. 656 (1960); *Associated Press v. United States*, 326 U.S. 1 (1945).

Neither do the First or Seventh Circuit decisions cited by OPS conflict with the Ninth Circuit's approach to horizontal conspiracy in *Hahn*. *Kartell v. Blue Shield of Massachusetts, Inc.*, 749 F.2d 922, 925 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985) (no allegation or evidence that defendant Blue Shield plan was controlled by competing physicians); *Brillhart v. Mutual Medical Insurance, Inc.*, 768 F.2d 196, 199 (7th Cir. 1985) (vertical arrangement between plan and member physicians, with all physicians free to join; plaintiff chose not to).

Finally, *Hassan v. Independent Practice Associates*, 698 F. Supp. 679 (E.D. Mich. 1988), cited by OPS as "illustrative" of joint venture analysis, see Section IIB *infra*, is in fact illustrative of the correct approach to the "specialist control" or "actual competitor" requirement that OPS seeks to engraft onto § 1 analysis. In *Hassan*, defendants argued that because "persons with allergy testing privileges and competency did not control decision-making with regard to allergy testing reimbursement levels," plaintiff allergists could show no agreement among competitors for purposes of their price-fixing claim. The court disagreed:

> In *Maricopa*, the Court apparently assumed that there was a conspiracy; as plaintiffs point out, the individual practitioners in *Maricopa* included both general practitioners and specialists. The same thing happened in *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 95 S. Ct. 2004, 44 L.Ed.2d 572 (1975), in which the Court found illegal a fee schedule that fixed the prices for title examinations. The Court made no distinction as to whether the committee setting the fee was controlled by lawyers who did title searches. Similarly, there is no reason to distinguish this case from the above. Health care providers do set the fee reimbursement in this case. In this case, it also appears that services performed by allergists are also provided by other physicians. For example, as plaintiffs point out, the IPA fee schedule sets a price for an initial exam as well as office

> visits, which schedule applies to all physicians (IPA Fee Schedule). Moreover, there is no question but that general practitioners see patients for many of the same ailments that an allergist might treat. Finally, at least one of the tests mentioned above that plaintiffs perform on all asthmatic patients, the pulmonary function studies, is also performed by other specialists, including cardiologists.

Id. at 687 (footnote omitted).

B. *The Ninth Circuit Followed* Matsushita *in Concluding That Plaintiff Doctors Had Made a Sufficient Factual Showing To Survive Summary Judgment and That the District Court Had Acted Precipitously in Dismissing Their Claims.*

The summary judgment standard applied by the Ninth Circuit is in accord with that developed by this Court, in *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242 (1986) and *Celotex Corp. v. Catrett*, 477 U.S. 317 (1986), as well as in *Matsushita*, 475 U.S. 574 (1986), in the specific context of antitrust claims. *Hahn*, 868 F.2d at 1026. *On the record before it*, the court found that plaintiff Doctors had produced sufficient evidence to withstand a motion for summary judgment and explicitly so stated:

> In other words, the appellants have introduced sufficient evidence to permit a trier of fact to conclude that the OPS plan was, in fact, 'an organization of physicians,' *Barry*, 805 F.2d at 868, or 'an agent [ ] of [its] member physicians,' *Virginia Academy*, 624 F.2d at 480. A trier of fact could reasonably conclude that the physician board members, even if not themselves competing directly with podiatrists, shared similar economic interests with those board members and OPS physicians who did compete directly, and that therefore the OPS board as a whole may have acted in the anticompetitive interests of those member physicians who compete with podiatrists for the provision of foot care.

868 F.2d at 1030.

Contrary to OPS's assertion, the summary judgment standard does not make it "an antitrust plaintiffs' burden to present sufficient evidence *to prove its case* on defendant's motion for summary judgment." OPS Petition at 14 (emphasis added), *citing Dunnivant v. Bi-State Auto Parts*, 851 F.2d 1575, 1579-80 (11th Cir. 1988). What the Eleventh Circuit actually said in *Dunnivant* is that the nonmoving party has the burden of producing evidence "which creates a triable issue . . .". *Id.* at 1579. Nor does the standard set out in *Monsanto* permit the trial court to "balance all the evidence pointing toward conspiracy against all the evidence pointing toward independent action." *Matsushita*, 475 U.S. at 600 (White, J., dissenting), as the district court in *Hahn* seemed to do.

The Ninth Circuit's application of this standard to the record before it is not at odds with any of the circuit court decisions cited by OPS, in which little or no evidence was presented in opposition to summary judgment. *E.g., Dreiling v. Peugeot Motors of America, Inc.* 850 F.2d 1373, 1379 n.3 (10th Cir. 1988) (cautioning against reversal of summary judgment based on speculation as to what evidence plaintiffs "could" or "might" possibly adduce to support their theories); *White v. Rockingham Radiologists, Ltd.*, 820 F.2d 98, 103 (4th Cir. 1987) (evidence on summary judgment held to conclusively establish unilateral action by defendant hospital); *Collins v. Associated Pathologists, Ltd.*, 844 F.2d 473, 477-79 (7th Cir.), *cert. denied*, ____U.S.____, 109 S. Ct. 137, 102 L. Ed. 2d 110 (1988) (plaintiff's evidence inadequate under *Matsushita* standard to withstand summary judgment on tying, boycott, and monopolization claims; court did not address the issue of conspiracy at all); *Health Care Equalization Committee v. Iowa Medical Society*, 851 F.2d 1020, 1032 (8th Cir. 1988) (where evidence showed that defendant Hospital Association had no authority or control over its member hospitals, plaintiffs' evidence that a member hospital once consulted the Association about a chiropractor seeking staff privileges did not rise above the level of a "metaphysical doubt" about a material fact

under *Matsushita* and did not exclude the possibility of independent or noninjurious action).

OPS cites *Houser v. Fox Theaters Management Corp.*, 845 F.2d 1225, 1229, 1231 n.13 (3d Cir. 1988) for the proposition that OPS "is not under any affirmative obligation to 'prove' the absence of conspiracy." OPS Petition at 14. No such burden was placed on OPS. The Ninth Circuit, having cited *Matsushita* for the standard of review, noted that where a plaintiff fails to produce any evidence of physician control of the price-setting entity, the agreements regarding prices and reimbursement would be upheld, *just as the court had done in Barry v. Blue Cross*, 805 F.2d 866 (9th Cir. 1986). Where there *is* evidence of a horizontal agreement among competing physicians, the agreements will be found unlawful under *Maricopa*. The evidence before the court was "more akin" to the latter and so plaintiff Doctors were correctly permitted to go forward to prove a conspiracy at trial.

Finally, nothing in *Pennsylvania Dental* constitutes a rejection of the principle that Blue Shield plans operating under the direction and control of member physicians, as agents of member physicians, are horizontal conspiracies. The Third Circuit did not reject application of the *Virginia Academy* court's conspiracy theory because it viewed it as analytically flawed; rather, *the court found that "the uncontroverted facts furnish no support for it."* 745 F.2d at 258 (emphasis added).

Similarly, the Fifth Circuit in *Consolidated Metal Products, Inc. v. American Petroleum Institute*, 846 F.2d 284, 293-94 (5th Cir. 1988), held only that "a trade association is not *by its nature* a 'walking conspiracy,' its every denial of some benefit amounting to an unreasonable restraint of trade." (emphasis added). Unlike plaintiff Doctors in *Hahn*, plaintiffs in *Consolidated Metal Products* produced *no* evidence of conspiracy and in fact, on appeal they "no longer contend[ed] that

there was an anticompetitive conspiracy between its competitors and [the defendant trade association]." *Id.* at 293. The court's affirmance of summary judgment for the defendant is not surprising, and certainly not in conflict with the result in *Hahn*.

II. The Ninth Circuit Correctly Determined — After Surveying the Constellation of Health Care Plan Antitrust Cases — That Evidence Produced So Far Makes This Case "Akin to *Maricopa*."

In finding the case presented by plaintiff Doctors' evidence "akin to *Maricopa*," 868 F.2d at 1029, the Ninth Circuit indicated (1) that *Maricopa* governs when physicians control a health care plan, *id.* at 1027; (2) that *Maricopa* is one of the cases that stands for the "broad proposition" that where physicians or the "relevant group of competitive providers" control the health care plan, the plan may not reimburse members and nonmembers differently in price or manner, *id.* at 1028; and (3) that physicians are the "relevant group of competitive providers" with respect to podiatrists, in light of the scope of podiatrists' licensure and the number of medical specialties that perform the same procedures as podiatrists. *Id.* at 1029, 1030.

Plaintiff Doctors' evidence supports each of these three bases for application of the rationale of *Maricopa*. First, evidence showed that physicians formed a majority of the OPS board during all relevant years. OPS may cling to the mere existence of a 1978 amendment to the OPS bylaws that required 50% non-physician membership on the board; the evidence before the Ninth Circuit, however, in the form of testimony by Mr. Rod Bunnell, OPS Senior Vice President and General Counsel, established that the "goal" of a 50-50 ratio was not met for any one of the relevant years of this litigation.[11]

[11] CR 544 at 156.

Second, OPS reimbursed members and nonmembers differently. The difference in "manner" of reimbursement consisted of payment to members at a rate up to the 90th percentile of the "usual, customary and reasonable" rate. Nonmembers, on the other hand, were reimbursed based on a fixed indemnity schedule. The difference in "price" based on this "two-tier" system was also demonstrated: "Appellants produced evidence that, on average, OPS members received from OPS 76 cents on the dollar billed, while OPS paid podiatrists only 50 cents on the dollar billed." 868 F.2d at 1025.

OPS's attempt to cloud the issue by vague reference to "a number of different policies," OPS Petition at 18, is of no avail: Mr. Bunnell testified as follows:

> Q. Would you say that, as a general matter, and I'm not saying in all cases, I'm saying as a general proposition the overwhelming majority of policies issued by OPS, both group and individual, that member physicians were paid on a different basis than non-member physicians?
>
> A. Yes, I think that's a fair statement.[12]

OPS also alludes to "copayments, deductibles, and other charges," OPS Petition at 19; the record before the Ninth Circuit contained no evidence of the existence of such charges or the number of policies that contained them, or whether such charges were not in fact a *neutral* factor, paid equally whether the service was provided by a member or nonmember.

Finally, physicians were the "relevant group of providers" competing with podiatrists, *see* Section IA, *supra*, as evidenced by comparison of their licensures, review of medical specialties that performed podiatric procedures, and review of covered services under OPS contracts.

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[12] CR 544 at 213.

Thus the Ninth Circuit's conclusion that plaintiff Doctors could proceed to trial on their horizontal price-fixing claim is not in conflict with the First Circuit's decision in *Kartell*, the Third Circuit's decision in *Pennsylvania Dental*, or the Seventh Circuit's decision in *Brillhart*, in all of which plaintiffs made no showing that they were excluded from membership and as a consequence reimbursed in a different manner and at a different price by a plan controlled by their competitors.

Neither is there a conflict with the Second Circuit's holding in *Medical Arts Pharmacy v. Blue Cross*, 675 F.2d 502 (2d Cir. 1982), in which the court declined to apply per se price-fixing analysis to a prescription drug program similar to that in *Kartell*. Blue Cross was the purchaser of prescription drugs and therefore its establishment of the maximum price it would pay participating pharmacies was a benign agreement on price between the contracting parties themselves and not an illegal agreement to fix prices charged in transactions with third parties. The court specifically found that the plan was not a horizontal price agreement among competitors, as in *Maricopa*, and its reference to the Justice Department's position, OPS Petition at 18, notes that price agreements *among competing pharmacists* would be illegal horizontal price-fixing. *Id.* at 506 n.4.

A. *The Ninth Circuit Had No Reason to View Plaintiff Doctors As Lacking Standing: Both They and Their OPS Subscriber Patients Were Injured By OPS's Policies.*

Both plaintiff Doctors and their OPS subscriber patients were direct victims of OPS's anticompetitive practices in the relevant market for foot care.

The plaintiff Doctors received a lower rate of reimbursement and then had to decide whether to attempt to collect the full fee. They submitted evidence that they often did not balance bill in the interest of not alienating or losing the

subscriber as a patient. (The First Circuit's holding with respect to balance billing in *Kartell* has no application to the facts here; because the Blue Shield plan in *Kartell* was an independent health care insurer that did not exclude entire classes of health care providers from membership, its ban on balance billing by members was lawful.) Plaintiff Doctors also presented evidence of shifts in consumer demand away from podiatrists' services as a result of OPS reimbursement practices.

The subscribers' injuries occurred when they realized an obligation to pay an out-of-pocket balance to a nonmember podiatrist because of the lower rate of reimbursement by OPS for podiatrists' services.

This Court has recognized that "the task of disentangling overlapping damages claims is not lightly to be imposed upon potential antitrust litigants, or upon the judicial system." *Blue Shield of Virginia v. McCready*, 457 U.S. 465, 475 n.11 (1982). The opinion in *McCready* also implies that if McCready had discontinued seeing the psychologist because of Blue Shield's reimbursement policies, the psychologist would have had standing to pursue an antitrust claim. *Id.* at 483.

Because of the evidence of lower rates of reimbursement and shifts in consumer demand, plaintiff Doctors are the point where price-fixing first was felt, like the wholesaler in *Illinois Brick Co. v. Illinois*, 431 U.S. 720 (1976). Plaintiff Doctors are not precluded from bringing their claim because *others* may also have been injured by the anticompetitive practices at issue. The congressional intent behind the Sherman Act is to encourage individuals who suffer antitrust injury to act as " 'private attorneys general.' " *Hawaii v. Standard Oil Co.*, 405 U.S. 251, 262 (1972). Further, there can be no duplicative recoveries if plaintiff Doctors pursue their claim; the statute of limitations bars any claim by OPS subscribers who did pay a balance bill, leaving the Doctors as the sole plaintiffs. 15 U.S.C. § 15b.

B. *The Ninth Circuit Recognized That Under* Maricopa, *OPS Had Not Shown Itself to Be the Type of Arrangement in Which Price Fixing Agreements Among Physicians Are Proper.*

The Ninth Circuit correctly noted that *Maricopa*'s *per se* analysis is controlling when there is "evidence to suggest that physicians controlled the . . . plan." *Hahn*, 868 F.2d at 1028. Because plaintiff Doctors' evidence was sufficient to raise an issue of fact regarding physician control, the court was correct to reverse the grant of summary judgment to OPS, holding that "[i]f the OPS plan was, in fact, a horizontal agreement among competitors, it was unlawful *per se*." *Id.* at 1030.

OPS makes much of footnote 5 in the Ninth Circuit's opinion, *id.* at 1029, characterizing it as "an attempt to expand liability beyond that found by this Court in *Maricopa* . . . ." OPS Petition at 23.

The footnote is faithful to and in no way conflicts with this Court's distinction between fee setting by a medical foundation "composed of individual practitioners who compete with one another for patients" and "partnerships or other joint arrangements in which persons who would otherwise be competitors pool their capital and share the risks of loss as well as the opportunities for profit." *Maricopa*, 457 U.S. at 356.

In the circuit court decisions cited by OPS that address Blue Shield plans, *Kartell*, *Royal Drug*, *Medical Arts Pharmacy*, and *Pennsylvania Dental*, no evidence of provider control of the plans was presented. Consequently, these courts had no occasion to consider whether or not the Blue Shield plans at issue constituted legitimate joint ventures. OPS's reliance on these cases is misplaced.

Hassan v. Independent Practice Associates, 698 F. Supp. 679 (E.D. Mich. 1988), also cited by OPS, involved a true joint venture which was, under *Maricopa*, exempt from *per se* analysis. Independent Practice Associates (IPA), a corporation

made up of and owned by physicians and osteopaths, provided medical care to Health Plus, a health maintenance organization. The court found that IPA member physicians shared the risks of loss as well as the opportunities for profit by accepting a "capitation" payment from Health Plus (unlike the physicians in *Maricopa*). Evidence in the record indicated that these risks were real and that some physicians had lost the entire amount at risk (retained by Health Plus in a "risk withhold" fund) because their expenses exceeded the capitation payments made to them.

OPS presented no analogous evidentiary record on summary judgment. In *Hahn* as in *Maricopa*, "the fee agreements disclosed by the record in this case are among independent competing entrepreneurs." *Maricopa*, 457 U.S. at 357. The Ninth Circuit correctly treated OPS as neither an insurer nor a joint venture; having reviewed the *Maricopa* articulation of the types of arrangements among physicians pursuant to which price fixing would be proper, the court noted that "no such arrangement is present in this case." *Hahn*, 868 F.2d at 1029 n.5.

III. The Ninth Circuit Correctly Permitted the Group Boycott Claim to Proceed to Trial: Plaintiff Doctors Sustained Their Burden of Raising a Reasonable Inference to Rebut OPS's Alleged Procompetitive Justification for Its Conduct.

The Ninth Circuit required OPS to proffer a "plausible, justifiable explanation of its conduct" in excluding an entire class of competing health care providers from membership. *Hahn*, 868 F.2d at 1026, *citing Matsushita*, 475 U.S. at 588. OPS did not proffer one "plausible" or "justifiable" explanation, much less "a number of proper justifications for its conduct . . ." OPS Petition at 25. There was simply no evidence in the record to support its single claim of "problems with

podiatrist overutilization" as a justification for their exclusion and in fact the claim was so vague and unsupported that the reviewing court was unclear as to what OPS's contention was. *Hahn*, 868 F.2d at 1031 n.10.

The record did, however, raise a "reasonable inference, grounded in evidence, to refute OPS's claimed justification." *Id.* at 1031 (citing evidence from an OPS board member that considerations of cost or overbilling were never made, as well as evidence that podiatrists' costs for foot care were, in fact, lower than those of OPS member physicians).

Whether the exclusion of podiatrists can in fact be sustained or rather should be condemned "should be determined after a fully developed record at trial." *Id.* at 1032. OPS makes a conclusory assertion that in permitting the group boycott claim to proceed to trial, the Ninth Circuit here is in conflict with *Northwest Wholesale Stationers, Inc. v. Pacific Stationery and Printing Co.*, 472 U.S. 284 (1985). OPS then asserts that in *Northwest*, the Ninth Circuit had injected a "fairness" doctrine into boycott theory and its decision was reversed by this Court on that basis. OPS Petition at 26. OPS supplies no analysis of how, even if its reading of *Northwest* were correct, it has any application to the Ninth Circuit's treatment of the group boycott claim in *Hahn*.

In *Northwest*, there was a nondiscriminatory expulsion of a cooperative member under facially neutral bylaws. In *Hahn*, as the Ninth Circuit noted: "OPS does discriminate against a class of providers," and its two-tier fee system, "when coupled with OPS's long refusal to admit podiatrists," makes it "doubtful whether OPS was, in fact, 'willing to purchase services from all [practitioners] on equal terms.' " *Hahn*, 868 F.2d at 1031; *accord, Barry v. Blue Cross*, 805 F.2d 866, 873 (9th Cir. 1986) (no illegal boycott where Blue Cross "does not discriminate against a particular class of medical provider, but instead is willing to purchase services from all physicians on equal terms.").

There is also no conflict between the Ninth Circuit opinion and *Moore v. Boating Industries Associations*, 819 F.2d 693 (7th Cir.), *cert. denied*, ____U.S.____, 108 S. Ct. 160, 98 L. Ed. 2d 115 (1987), in which the court rejected plaintiffs' group boycott theory when plaintiffs presented no evidence of anti-competitive purpose or anticompetitive effect.

The First Circuit's decision in *Kartell* is, as discussed *supra*, distinguishable because there was no evidence that the Blue Shield plan was a horizontal combination; since Blue Shield was acting unilaterally, it had " 'a right to deal, or refuse to deal, with whomever it likes, as long as it does so independently.' " 749 F.2d at 932. Similarly, in *Pennsylvania Dental*, plaintiffs failed to show the concerted action necessary to establish an illegal boycott. 745 F.2d at 259-60. Finally, the Fifth Circuit in *Royal Drug* began its group boycott analysis with the point that dispositively distinguishes the case from *Hahn*: every pharmacy had the same option to participate in the plan.

A. *The Ninth Circuit Appropriately Found Plaintiff Doctors' Evidence of Actual Detrimental Effects Sufficient to Take Their Group Boycott Claim to Trial.*

Plaintiff Doctors showed actual adverse effects on competition for foot care services from OPS's membership and reimbursement policies: podiatrists were excluded from acting as "equal competitors" with OPS member physicians in providing foot care to 25% of the insured patients in the Portland metropolitan area,[13] and consumer demands for podiatrists' services shifted to OPS member physicians who performed foot care.

[13] While OPS insured 16% of the total population of the Portland metropolitan area, plaintiff Doctors presented evidence from their economics expert witness that in a selected year (1982), OPS insured over 25% of the *insured* population of the Portland metropolitan area. CR 597 at 9.

Under this Court's reasoning in *Indiana Federation*, plaintiff Doctors' showing was sufficient to withstand a motion for summary judgment, even absent proof of market power, since " 'proof of actual detrimental effects . . .' can obviate the need for an inquiry into market power, which is but a 'surrogate for detrimental effects.' " 476 U.S. at 460-61.

Plaintiff Doctors submitted evidence to the district court, in support of their motion for summary judgment, that although podiatrists' share of the foot care market was 30% under a nondiscriminatory plan, it had been cut to 10% under the OPS reimbursement scheme, during the same time period and in the same market. This effect was calculated by plaintiffs' economics expert witness to represent $690,000 in revenues shifted from the six plaintiff Doctors to OPS member physicians;[14] this calculation did not take into account the additional lost revenues of other Oregon podiatrists. These shifts demonstrated skewing of consumer preference, "actual detrimental effects" in the foot care market that require no further proof of OPS's market share.

Plaintiff Doctors did, however, present evidence of market power: from 1975 to 1981, physicians were responsible for 90% of foot care billings to OPS, which the Ninth Circuit found to suggest that "OPS member physicians are a significant competitive force in the Portland foot care market." *Hahn*, 868 F.2d at 1030.

Considerations of "pure" market power, for purposes of, *e.g.*, a monopolization claim under § 2, must be distinguished from market power as a "surrogate" for actual detrimental effects upon competition. Where antitrust plaintiffs make a showing of actual anticompetitive effects, the need for the surrogate is obviated and plaintiffs' claim may go forward.

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[14] CR 548 at 148.

B. *The Ninth Circuit Had Before It Evidence of Injury to Competition for Provision of Foot Care in the Form of Documented Shifts in Consumer Demand for Podiatrists' Services.*

As detailed in Section IIIA *supra*, plaintiff Doctors presented evidence of antitrust injury to competition, in the form of price-sensitive shifts in consumer demand for podiatrists' services; affidavits of former patients of plaintiff Doctors were submitted, documenting that after learning of OPS's lower level of reimbursement to podiatrists, patients declined to return to podiatrists for foot care for financial reasons.

In the cases cited by OPS as being in "conflict" with the Ninth Circuit's decision in this case, courts found only proof of injury to the individual plaintiff competitors and no injury to competition, a scenario quite distinct from that presented by the record in this case. *E.g., Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477 (1977) (loss of anticipated profits inadequate antitrust injury); *Kartell*, 749 F.2d 922 (1st Cir. 1984) (where effect of alleged predatory pricing by Blue Shield, as a single-entity insurer, would impact insurance market, possibility of injury to physician/supplier of medical services too remote and indirect to confer standing); *Irving Ear, Nose, Throat & Allergy Clinic v. Group Hospital Service, Inc.*, 776 F.2d 1046 (5th Cir. 1985) (plaintiff physician showed only that insurer's cost containment program injured *his* practice and reduced *his* income); *Zinser v. Rose*, 868 F.2d 938 (7th Cir. 1989) (claim that insurers unilaterally set limits on reimbursement for chiropractic services, with no allegation or evidence of horizontal conspiracy, insufficient to support claim of antitrust injury).

CONCLUSION

Because the Ninth Circuit's opinion is in harmony rather than in conflict with the decisions of this Court and the other circuits that have addressed competitor-controlled health care plans, Respondents respectfully request that this Court deny the Petition for Writ of Certiorari.

DATED this 2nd day of August, 1989.

Respectfully submitted,

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No. 89-13

IN THE SUPREME COURT

OF THE UNITED STATES

OCTOBER TERM, 1988

OREGON PHYSICIANS' SERVICE,
an Oregon nonprofit corporation,

Petitioner,

v.

JOHN HAHN, VADE LIGGETT,
JOSEPH AIZAVA, V.G. LIVINGSTON,
HUGH FRASER, and HIDE AIZAWA,

Respondents.

On Petition For Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITIONER'S REPLY AND SUPPLEMENTAL BRIEF

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PARTIES TO PROCEEDINGS

Petitioner Oregon Physicians' Service has already noted in its petition that it merged with Northwest Hospital Service (dba Blue Cross of Oregon), which became Blue Cross and Blue Shield of Oregon, a nonprofit health care service contractor under Oregon law. In addition to its involvement in the joint venture identified in the petition, Blue Cross and Blue Shield of Oregon is the sole member in two separate nonprofit membership corporations: Capitol Health Care, a health care service contractor and federally qualified health maintenance organization; and Columbia Health Service, a health care service contractor in the State of Washington. In turn, Capitol Health Care has a wholly owned subsidiary: Capitol Health Management, Inc., a stock corporation. In turn, Capitol Health Management, Inc. is a holding company for Health Maintenance Of Oregon, Inc., a health care service contractor and federally qualified health maintenance organization; and Preferred Health Northwest, Inc., a stock health care service contractor. Blue Cross and Blue Shield of Oregon also has two wholly owned subsidiaries: Oregon Pacific States Insurance Company, a stock corporation life and health insurer; and Total Plan Alternatives, Inc. (fka Oregon Coordinated Services, Inc.), a stock corporation third-party administrator.

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Pursuant to Supreme Court Rules 22.5 and 22.6, petitioner Oregon Physicians' Service ("OPS") submits this reply and supplemental brief in support of its petition for a writ of certiorari.

I. By Ignoring Petitioner's Status as an "Insurer" and Allowing an "Inference" of Conspiracy Because Some Physicians Perform Services Like those Performed by Plaintiff-Respondent Podiatrists and Some Other Physicians are Members of Petitioner's Corporate Board, the Ninth Circuit Here Conflicts with Other Courts' Holdings That a Blue Shield Defendant is a Single Economic Entity and Insurer Not Constituting by its Nature a Conspiracy.

To prevail on their Sherman Act Section 1 claims, respondents must first come forth with evidence to convince a reasonable fact finder that there was a conspiracy to restrain trade. Respondents do not contend that there was any direct evidence of a conspiracy, but instead argue that they could rely on an "inference" of conspiracy. Even assuming respondents' characterization of their "evidence" is correct,[1] it is not reasonable to "infer" that there was a conspiracy by the single defendant nonprofit Blue Shield corporation against respondents, and the Ninth Circuit ruling to the contrary here sets a dangerous precedent.

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[1] Petitioner OPS disagrees with much of respondents' characterization of the evidence of record, but for purposes of argument here, will assume the "evidence" is as cited to the record, or quoted from the Ninth Circuit opinions. In any event, the legal question here is what inferences can reasonably be drawn from such "evidence," which question should be and has been resolved as a matter of law by other courts, in conflict with the rationale and result reached by the Ninth Circuit here.

Throughout their brief, respondents rely upon what they characterize as the Ninth Circuit's rejection of "insurer" status for petitioner nonprofit health care contractor OPS. This rejection is a necessary predicate for a number of their contentions, including their argument regarding conspiracy: in order to evade authority that a corporation such as petitioner cannot conspire with itself, respondents attempt to side-step this issue by contending that petitioner is not an "insurer," but merely an "agent" of its member physicians. Not only does such rejection of petitioner's corporate "insurer" status and bald "inference" of conspiracy fly in the face of Oregon's statutory recognition and regulation of petitioner,[2] but it conflicts with numerous holdings from other circuits to the contrary.

Respondents here do not present any argument or evidence that petitioner operated in any way contrary to the Oregon statutes.[3] Instead, they argue, and the Ninth Circuit relied upon, a single case to "infer" a "walking conspiracy": *Va. Academy of Clinical Psy. v. Blue Shield of Va.*, 624 F.2d 476 (4th Cir. 1980). There, the court had

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2 Oregon explicitly acknowledged petitioner's status as a nonprofit health care service contractor corporation under ORS 750.005 (2)(a). (Petition No. 82-1773, Appendix B at 5 n.1; Appendix M at 103.) As a nonprofit health care service contractor, petitioner was regulated and supervised under the Oregon Insurance Code, which included a requirement that its policies generally be reviewed and approved by the Insurance Commissioner. ORS 750.055; 743.006, 743.009 (Appendix M at 105-109; Appendix K at 99-101).

3 In *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), also cited by respondents and the Ninth Circuit, the two defendant plans were not "insurers," defined in that opinion as one who bears the risk of subscribers needing services. 457 U.S. at 339 n.7. Here, petitioner OPS is such an "insurer" (and ultimately, if the "risk withhold" is activated, OPS "members" would share in this risk).

before it two Blue Shield plans which it found had conspired with one another to implement a requirement that psychologists "bill through" a physician in order to be paid, contrary to Virginia law. 624 F.2d at 478-479, 481 ("the Plans had 'collaborated'"), 482 ("collective action of the Plans"), 483 ("defendants' policy"). Hence, there was no need to "infer" a conspiracy because there was direct evidence of an actual conspiracy: the court gratuitously "found" that those two Blue Shield defendants were "agents" of their physician members. 624 F.2d at 480-481.

Petitioner has already cited numerous cases in other circuits which have rejected such an "inference" of a "walking conspiracy". The Sixth Circuit recently followed a number of those cases in *Tennessean Truckstop, Inc. v. NTS, Inc.*, 875 F.2d 86, 90 (6th Cir. 1989), holding:

> "Blue Shield * * * existed for a legitimate purpose, namely the provision of medical insurance. * * *
>
> " * * * The fact that NTS--which bears the credit risk--expects to be paid by the end user does not make it a 'sham' organization, any more than the fact that Blue Shield is paid by its subscribers makes Blue Shield a 'sham' organization."

As noted recently in *Westchester Radiological v. Empire Blue Cross,* 707 F. Supp. 708, 711 n.6 (S.D.N.Y. 1989), for antitrust purposes the defendant Blue Cross and Blue Shield could be treated simply as a buyer of services where it pays the health care bill and seeks to set the amount to be paid (citing, inter alia, cases also cited in the petition here).

Respondents also attempt to bootstrap an "inference" of conspiracy from "evidence" that some physicians compete with them, and some other physicians

were on petitioner's corporate board. This, standing alone, simply cannot support an inference of conspiracy under decisions of this Court and other courts. The mere opportunity for potential competitors to meet does not amount to conspiracy: to hold otherwise, as does the Ninth Circuit here, is to condemn as a "walking conspiracy" any health care entity in which medical doctors participate. As another court has recently observed, "the mere opportunity to conspire among antitrust defendants is insufficient to permit the inference of conspiracy." *Sweeney v. Athens Regional Medical Center,* 705 F. Supp. 1556, 1565 (M.D. Ga. 1989), quoting *Bolt v. Halifax Hosp. Medical Center,* 851 F.2d 1273, 1286 (11th Cir. 1988) [opinion reinstated in part and remanded to panel for further consideration of a petition for rehearing, 874 F.2d 755 (11th Cir. 1989)(en banc)].

The Ninth Circuit's suggestion that such a mere possibility of conspiracy is sufficient here[4] is in direct conflict with not only this authority, but the other authority set forth in the petition. Further, in *Thompson v. Wise General Hosp.,* 707 F. Supp. 849, 852 (W.D. Va. 1989), the court held that an inanimate institutional

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[4] The Ninth Circuit's and respondents' citation to *Radiant Burners, Inc. v. Peoples Gas, Light & Coke Co.,* 364 U.S. 656 (1961) simply does not support their position. There, reviewing the grant of a motion to dismiss, the Supreme Court had before it ten members of a standards-setting association named as co-defendants, six of whom directly competed with plaintiff, with an allegation (that had to be assumed true) that those co-defendants actually "conspired" to completely eliminate plaintiff. Similarly, respondents' citation to a concurring opinion in *Associated Press v. United States,* 326 U.S. 1 (1945) is inapposite, not only because it is the sole opinion of one member of that Court, but because there, as the quote reflects, there were individual defendants demonstrably conspiring against direct competitors.

defendant cannot conspire by itself: some human individuals must be involved. In the absence of any specification of the who, when, how, and where, plaintiffs simply failed to demonstrate a conspiracy. *Id.*

The Ninth Circuit's failure to acknowledge petitioner OPS' status as a nonprofit health care service contractor corporation under the supervision of the Oregon Insurance Commissioner, and its failure to follow its sister circuits' holdings that a Blue Shield defendant in these circumstances is an independent economic actor, led to its erroneous acceptance of respondents' theory that notwithstanding the lack of any evidence of conspiracy, there was an "inference" that OPS is nothing more than an "agent" of its "member" physicians: in essence, a "sham". Under decisions of this Court and other courts, there has to be something more shown--some sort of "anticompetitive intent" or activity not present on this record--in order to support a finding of conspiracy.[5] Respondents have not identified a single

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[5] Respondents now argue that physicians could not compete with dentists, in an attempt to "distinguish" *Pa. Dental Ass'n v. Medical Serv. Ass'n of Pa.*, 745 F.2d 248 (3d Cir. 1984), upon which the District Court here explicitly relied. Petitioner OPS notes that by licensure, physicians could potentially "compete" with dentists, just as they could potentially compete with podiatrists such as respondents, because generally physicians are not prohibited by licensure from work on the oral cavity or the foot. For example, some physicians and dentists do reconstructive work involving the face and jaw: dentists specializing in this work are known as maxillofacial prosthodontists. *Murphy v. Aetna Life and Casualty,* 1988-2 CCH Trade Cases ¶ 68,240 (D. Or. 1986) (dentist brought antitrust claims challenging, inter alia, exclusion of dentists from definition of "physician"), affirmed without published opinion, 815 F.2d 714 (9th Cir.), dismissed for want of jurisdiction, __ U.S. __, 108 S. Ct. 447, 98 L. Ed. 2d 387 (1987), rehearing denied, __ U.S. __, 108 S. Ct. 1126, 99 L. Ed. 2d 286 (1988).

instance of "conspiracy," a single "co-conspirator," or any other "facts" necessary in order to make a prima facie case of conspiracy,[6] and accordingly the Ninth Circuit holdings here which approve an "inference" of conspiracy are contrary to decisions of a number of courts from other circuits. This Court should grant the petition to review this conflict.

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6 Respondents and the Ninth Circuit obliquely refer to "evidence" that "suggests" petitioner did not consider costs and overutilization as reasons for not inviting respondents to become members, citing deposition testimony of one of petitioner's board members. In that deposition, the board member merely stated that he did not recall whether such overutilization was considered and that costs might have been considered, and set forth very briefly his understanding of the historical evolution of Blue Shield plans. Respondents fail to acknowledge that the managers and employees responsible for preparing and presenting reports to the board specifically stated that they were concerned with costs and overutilization in connection with podiatrists' billing practices: in particular, podiatrists appeared to bill for a single surgery operation by billing under a number of different component procedures, thereby increasing the total bill. Affidavit of Suzanne Gilkey (September 26, 1983); Deposition of Suzanne Gilkey (July 2, 1986); Deposition of Roderick Bunnell (July 1, 1986). Furthermore, some specifically negotiated subscriber contracts-- including the subscriber contract for the Oregon Medical Association -- had coverage for 100 percent of all providers' billings (including nonmembers such as respondents). Deposition of Roderick Bunnell (July 1, 1986); Deposition of Marvin Urman (July 3, 1986). The fact that the medical doctors themselves specifically negotiated full payment for all providers, including respondents, hardly supports an inference that those medical doctors conspired against respondents. Likewise, the fact that petitioner at one point invited optometrists, not podiatrists, to membership, does not give rise to an "inference" of conspiracy. The Oregon legislature has never mandated "equality of insurance treatment" for podiatrists. (See Petition No. 82-1773, Appendix B at 23-24). However, the Oregon legislature did enact just such a statute for services of optometrists. ORS 750.065. (Appendix M at 109-110).

II. Allowing Respondents to Proceed Is Contrary to This Court's and Other Courts' Holdings That In These Circumstances There Is No Unreasonable Restraint, and Health Care Providers Lack Antitrust Standing Because They Cannot Demonstrate Antitrust Injury.

Respondents must also establish an unreasonable restraint of trade which resulted in injury to competition affecting interstate commerce.[7] Respondents now argue that there were two kinds of "injury," one from their own "balance billing" practices, and the other from a "shift" in consumer "preference." They provide no authority for either of their theories.

A recent Seventh Circuit decision stands in stark contrast with the result reached by the Ninth Circuit here. In *Schachar v. American Academy of Ophthalmology, Inc.*, 870 F.2d 391 (7th Cir. 1989), the court emphasized that defendant Academy did not attempt to coordinate its activities with any other

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[7] Contrary to respondents' statement in their brief, the issue of interstate commerce is one that might be appropriate for review by this Court. First, the issue is a legal one: the circuits have split on the test to apply, with the test applied by the Ninth Circuit in this case now specifically rejected by a number of other courts. Second, under the test applied by other courts, the district court here made an initial determination that there was no substantial link to interstate commerce: the previous Ninth Circuit panel had reversed because it determined the district court should have applied another standard. After applying that Ninth Circuit standard, the district court found that there was sufficient connection to interstate commerce to provide jurisdiction. Third, this is the appropriate time to raise this issue, because the Ninth Circuit standard was "law of the case" on this appeal. On this record, this Court could make a clear choice between the standards applied by other circuits and the initial district court decision here, or the Ninth Circuit one applied here.

independent actors (id. at 398), and that no restraint of trade was demonstrated where only competitors, not competition, may have been injured:

> " Antitrust law does not compel your competition to praise your production or sponsor your work.
>
> * * *
>
> "Animosity, even if rephrased as 'anticompetitive intent,' is not illegal without anticompetitive effect."870 F.2d at 399, 400 (citations omitted; emphasis added).

Respondents' complaint appears to be that under certain contracts between petitioner and its subscribers, subscribers would be reimbursed for respondents' services according to an indemnity schedule. As the Ninth Circuit acknowledged, this was "usually" at the 60th percentile. (Appendix A at 10; Appendix B at 30.) Under a 60th percentile schedule, subscribers would be reimbursed for bills paid to respondents up to the 60th percentile: if the respondents' bills were at a rate less than or equal to the 60th percentile, payment of those bills would be reimbursed in full and respondents might be paid an amount more than or equal to that paid by petitioner to 60 percent of its members! If respondents billed at a rate higher than 60 percent of petitioners' members, respondents had the option of seeking payment from a patient of whatever difference remained unreimbursed. If a subscriber of petitioner paid such a bill, it would be the subscriber who was out of pocket, not respondents: if the subscriber was not billed for (or did not pay) any such difference, then there was no extra charge, or "injury," to the consumer. In short, there is no unreasonable restraint of trade, and respondents cannot have standing to prosecute this case because there is no antitrust injury, either to themselves or to the consumer-subscribers. Respondents were free to deal

with subscribers of OPS, or any other consumer, and according to their own "evidence," did so.[8]

This lack of antitrust injury is illustrated by a number of recent decisions. For example, the Sixth Circuit in *Tennessean Truckstop* held that plaintiff there (like respondents here):

> "might have enjoyed more business than it now receives * * *. But this does not necessarily constitute an antitrust injury; the fact that a particular competitor in a particular market has lost profits does not inevitably mean that competition as a whole is lessened." 875 F.2d at 88.

Similarly, in *Key Enterprises of Delaware, Inc. v. Venice Hosp.*, 703 F. Supp. 1513, 1518-1519 (M.D. Fla. 1989), the court pointed out that plaintiff was not a consumer, and that although defendants' activities might have affected other health care providers, those activities did not injure the consumers, and therefore did not injure competition. The consumer was always free to choose among competitors.[9] *See Westchester Radiological,* 707 F. Supp. at 713 & n.11.

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8 Respondents champion "evidence" that they were responsible for 30 percent of the billings to Blue Cross, and hence were treating patients with other insurance coverage. In fact, respondents admit that petitioner covered no more than 16 percent of the Portland "market" which they themselves defined, and no more than 25 percent of the Portland "insured" market. That obviously left at least 75 percent of the market to respondents without having to deal with petitioner at all.

9 In *Key,* the court also held that there could not be any claim for "boycott" or refusal to deal, because defendants did in fact "deal" with plaintiff, albeit on defendants' own terms. 707 F. Supp. at 1519 n.7.

CONCLUSION

Because the Ninth Circuit holdings here conflict with decisions of this Court and other courts on matters of fundamental concern to the application of the antitrust laws to health care entities throughout this Nation, this Court should accept review.

Respectfully submitted,

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